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ABSTRACT

Material developed for a national conference of leaders in the applied and theoretical sectors of gerontology, mental health, and nursing home administration is provided in these proceedings. The purposes of the conference were to: develop priorities for populations for whom training would be offered; identify mental health content that is appropriate for inclusion in training programs; analyze ways in which projected content can best be translated into educational models; and identify potential organizations or groups of organizations for carrying out the program. The sections of the proceedings are as follows: Foreword; Prefatory Remarks; Introduction, by Jerome Kaplan; Themes and Issues--Major Perspectives, by Walther M. Beattie, Jr.; The Concept of Wholeness in Long-Term Care Facilities; An Examination of Mental Health Principles by a Psychiatrist, an Administrator, and an Educator--Concerning Decent Institutional Care, by Robert N. Butler; Continuing Education in a Long-Term Care Facility, by Arthur Waldman; The Educational Experience and the Role of the Educator in Training for Long-Term Care, by Jerome Hammerman. In addition, material prepared by conference participants, consisting of 32 papers, as aids in designing educational programs for administrators and staff of long-term care facilities is provided. A list of conference participants, a copy of the conference format, and a bibliography are included. (DB)

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Mental Health: principles and training techniques in nursing home care

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Mental Health: principles and training techniques in nursing home care

Material developed for a National Conference,

Bridging Continuing Education and
Mental Health in Long-Term Skilled
Institutional Care for the Elderly

Held at the Marriott Key Bridge Hotel
Washington, D. C., May 14-16, 1972

Sponsored by the Gerontological Society

National Institute of Mental Health
5600 Fishers Lane
Rockville, Maryland 20852

"For each age is a dream that is dying,
Or one that is coming to birth. . ."

S.W.E. O'Shaughnessey
1844–1881

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Foreword

By George L. Maddox, Ph.D.

RESEARCH and training in the interest of service to aging persons has been the continuing objective of the Gerontological Society for over a quarter of a century. So a conference on continuing education for those who serve the vulnerable aging persons who must be or live in special settings represents a natural expression of a basic commitment of the Gerontological Society and its Committee on Education. We are pleased to have had the opportunity, in cooperation with the Continuing Education Branch, National Institute of Mental Health, to develop a working conference on a topic of great social as well as personal interest.

The high prevalence of physical, psychological, and social disabilities which require special institutional environments for many aging persons is, appropriately, an issue of great national significance. The appropriateness of institutionalization, the quality of care for aging persons in special settings, and questions about the outcomes and cost of care in these settings are issues which require our careful consideration and most thoughtful response. Although it is attractive to assume that there are no problems which more money will not solve, this answer is a bit too facile. Special environments for vulnerable aging persons will not be satisfactory, no matter how much money is spent, until all the personnel in these settings are technically and socially competent to help and find personal satisfaction in helping. How to facilitate the development and retention of competent and satisfied personnel in the settings which serve vulnerable aging persons is what this working conference was all about.

The persons who participated had many reasons to be pleased. They may not have been pleased by the difficulty in communicating with one another or the failure to produce simple solutions for complex problems, but the conference was a necessary first step to productive exchanges for persons from throughout the United States who share a common commitment to improved quality of care for aging persons who must live in special environments.

A special debt of thanks is due to the Steering Committee of the working conference, to members of the Continuing Education Branch of the National Institute of Mental Health, and to the participants. We can build on the work begun at this conference. We must do so and do so quickly.

Prefatory Remarks

By The Continuing Education Branch,
National Institute of Mental Health

IN a statement released August 6, 1971, the President expressed the Administration's concern about the many nursing homes and related long-term care facilities that fall short in their capacity to provide quality care to residents, the vast majority of whom are elderly. The President outlined a "Plan for Action" to upgrade the quality of care in the nation's nursing homes that included a new program of short term training for personnel regularly involved in furnishing services to residents. The President's message stated, "In too many cases, those who provide nursing home care—though they have been generally well-prepared—have not been adequately trained to meet the special needs of the elderly. Our new program will help correct this deficiency."

The National Institute of Mental Health was given the responsibility for developing a program in the mental health aspects of nursing home care. Early in the implementation of this responsibility, the Institute turned to the Gerontological Society for assistance. After considerable discussion, the decision was reached to hold this National Conference for purposes of bringing together key leadership people from the theoretical and applied sectors of gerontology, mental health, and nursing home administration for the purposes of: developing priorities for populations for whom training would be offered; identifying mental health content that is appropriate for inclusion in training programs; analyzing ways in which projected content can best be translated into educational models; and identifying potential organizations or groups of organizations for carrying out the program.

This Conference, and these proceedings resulting from it, thus became a first step in a national program of linking mental health and continuing education resources with nursing homes and related long-term care facilities in order to minimize impairment of function caused by mental disorder and promote mental health of residents, thereby contributing to the improvement of the quality of care in nursing homes. It is the hope of the National Institute of Mental Health that conference participants and many others will find in these proceedings both conceptual and practical material that will be of assistance in planning and implementing training activities at the local, state, and regional levels.

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Introduction

By Jerome Kaplan, Ph.D.

IT is by looking at the past that we mirror the present. It is by assessing the present that we make it possible to plan for the future. In this sense, then, to understand how the mental health needs of the nursing home population may be better met through continuing education now and to determine the type of research needed to cope effectively with tomorrow, it is necessary to know how group living for the aged evolved historically from church and government among cultures now diffused through American Society.

In *Twenty Predictive Goals in Aging by the Year 2,000*, a 1969 commentary on aging and aged people and their institutions, I stated, "Housing to particularly serve the aged will be revolutionized due to . . . the evolving desires of those now young who will then be old. . . The home for the aged, as it has been known, will almost have disappeared. In its place will be an array of home health–housekeeping–cooking–personal attention services in conjunction with new types of housing to promote independent living. . . In the place of the hospital will come the Health and Service Center [that] will vary considerably [with] some specializing, primarily with the elderly as nursing homes now do. . . The key is that the Center will encompass the totality of care and social needs for that particular group." Note that, while homes for the aging may diminish, the "new" type nursing home concept envisaged here may grow.

These observations were professional judgment perspectives predicated on existing knowledge, selected trends, and an examination of prototypes in existence, such as those exemplified by the Philadelphia Geriatric Center and the Mansfield (Ohio) Memorial Homes, among several others. The extent to which the above predictions will manifest themselves will relate to a national policy resulting from federal decisions and the overall policy effect of the multiple national organizations serving elderly interests in some manner. It is hoped that such policies will be based on knowledge derived either through clinical experience and/or experimental research design rather than a pragmatic "push" of the day. However, unless our institutions incorporate the transmission of knowledge in an orderly manner, pragmatism and political expediency will "win out" over knowledge.

It is relatively clear where we have been historically in institutional life; it is less clear where we are now. And we can only project what type of institutional life we may have in the future.

The content from the Conference herein published implies that past patterns of group living for the elderly are not acceptable today; the present status of nursing home life is strongly questioned, although guidelines for directions in which we may be moving are beginning to appear. As had been requested, the conferees offer workable techniques and describe them sufficiently to indicate much potential for great strides in the 1970's.

They give evidence that the quality indicators of the nursing environment are in the process, albeit slowly, of being developed; that the interrelationships of the "higher" educational institutions with nursing homes and their mutual interfluence (word coined by J. Kaplan) are beginning to evolve; and though the full merging of the mental health needs of nursing home patients (almost exclusively older patients) and of the staff who serve the patients may not yet be possible, the possibility can be visualized within the next years, since recognition is now being given to the necessity for ascertaining such needs while simultaneously training to meet them.

It becomes obvious, then, that good research is a

necessary concomitant of training to more fully determine, not only what is needed within a nursing home to add to existing mental health knowledge, but also what techniques resulting from increasing knowledge are most successfully transmitted to and accepted by the staff.

Effective co-existence—not peace—is mandatory between the nursing home as a unit of the institution of health and the college/university as a unit of the institution of education. Each will learn from the other. As both learn to work together, the mental health components in nursing home care will evolve through implementation of the content described by the Conference participants.

Walter M. Beattie, Jr., is Director of the All-University Gerontology Center at Syracuse University, Syracuse, New York.

Themes And Issues–Major Perspectives

By Professor Walter M. Beattie, Jr.

MUCH is said by 60 participants during a three-day meeting. It is not possible to record each individual's contributions. It is, however, essential to capture the major themes and issues presented by educators, providers, and consumers involved in a crucial national issue–the issue of how those who care for the approximately 1,000,000 institutionalized elderly may be better educated in the mental health components of care, whether they be direct service personnel or administrators. What follows, therefore, is an attempt to capture main themes, central issues, and major perspectives.

The Conference was a "first" to attempt to bridge continuing education and mental health resources for those who care for older persons in nursing home settings. Because of the diversity of background of participants, language and meaning were concerns, yet new directions began to emerge and some bridging began to take place.

OBJECTIVES OF THE CONFERENCE

In opening the Conference, the seminar leader suggested that its purpose was to think together about issues involved in and approaches to the development of continuing education programs in the mental health components of care for personnel in long-term care facilities.

Speaking for the Continuing Education Branch of the National Institute of Mental Health, Mrs. Eleanor Friedenberg emphasized the desire of NIMH to bring together those from the field of mental health, those responsible for long-term care, gerontologists from a full range of settings, and specialists in continuing education. It was hoped that experts from these relevant backgrounds would stimulate each other's thinking in developing models of continuing education programs for personnel of long-term care facilities.

GOALS

From the opening session to the last speaker it was evident that the ultimate goal of institutional care must be intimately intertwined with the quality of care and the quality of life for residents in institutional settings. The specific goal of the Conference was to develop ways in which continuing education can contribute to the capabilities of personnel in long-term facilities toward attaining the ultimate goal. There was no immediate answer to the question posed at the opening session–how can we accomplish these aims?

The group did agree, however, that whether persons in long-term care institutions were referred to as residents, patients, or consumers, they must primarily be viewed as *citizens* with individual human, personal and civil rights. Further, it was felt that personnel should seek to broaden the range of choice for the older person and to maximize opportunities for the exercise of choice. Finally, it was felt that a goal of care should be to support and build upon the functional capacities of older persons, and that in so doing, it is important to assess not only individual functional capacities, but the environment itself to determine whether or not it supports such functions.

ORGANIZATIONAL CONCEPTS AND DIRECTIONS

At the opening session of the Conference Professor Jerome Hammerman stated that mental health care

involves legions of persons and is multidisciplinary in scope. It goes beyond psychiatry and social work. Critical issues include fragmentation, over-specialization, and resistance to change within the mental health system, with a strong push toward de-professionalization of services.

The following points concerning long-term care facilities were discussed:

- . . . that, as Dr. Robert Butler pointed out, it is no longer possible to distinguish between the populations of mental hospitals and of nursing homes, and that by 1975 it may well be that more aging persons will be in nursing homes than in hospitals. Thus, it will be necessary to raise the question as to the place of care and the right to service for the elderly among the broad array of facilities and services within a given community;
- . . . that land use and zoning and the potentials for housing and institutional care often determine where the facilities will be located, as well as the characteristics of the services provided;
- . . . that the majority of staff in mental health facilities on the community level have little or no knowledge of the aging process and that it is imperative that training programs be given on the site where services are provided;
- . . . that providers should regionalize and share their resources with one another as well as with educators;
- . . . that cooperative, integrated, coordinated services subject to evaluation as to their use and effectiveness are necessary to the successful operation of long-term care facilities;
- . . . that an organizational approach to providing continuing education for mental health components should have both academic and clinical bases, with the latter providing opportunities for learning and training in urban, suburban, and rural settings.

Also under discussion were trends that presage an upswing in the quality of long-term care for the elderly. Among them is the community college in rural areas, seen as a major resource for serving smaller proprietary nursing homes. Heretofore, the distance to larger universities and educational facilities for training posed a deterrent to ongoing education for personnel in these nursing homes. Another major organizational concept is that of comprehensive health planning programs which will serve to close the communication gap between homes and other health and social care facilities.

There is, and will continue to be, a trend towards specialization of tasks and knowledge. At the same time, there is movement in the direction of coordination, often on a regional basis, of facilities and services through "official" health planning agencies. Participants noted in passing that, as coordination increased, it was essential to avoid borrowing indiscriminately from hospitals the service specialization approach.

PHILOSOPHY AND KNOWLEDGE

To achieve goals it is essential to have a philosophy about and knowledge of older persons. Implicit throughout the Conference were the following philosophical concepts:

- . . . that each older person has the right to self-mastery of his own person as well as of his environment within the limitations of his functional capacities;
- . . . that self-actualization and human development is a life-long process;
- . . . that societal forces and approaches to aging tend to denigrate, segregate and isolate older persons, increasingly taking away their rights to independence and interdependence;
- . . . that social definitions of aging are not inherent in the biological or psychological processes of aging;
- . . . that the right to choice and of options in decision making is significant in the lives of all individuals and that society increasingly restricts the exercise of the right of choice in the latter stages of life;
- . . . that there is a need to legitimize and make relevant the latter stages of life and their significance to older persons, their families, and society;
- . . . that there is a need to recognize the changes that occur in people as they grow older, requiring societal responses and services to them to be highly individualized;
- . . . and that life is a continuum within which, at times, discontinuity occurs for older persons; that present responses have roots in the past and that there is need to bridge the present with the past, as well as to support older persons in responding to the present and preparing for the future.

Participants also explicitly identified more specific issues around which knowledge must be better developed and transmitted to personnel working with older people. Among these are situations involving separation, such as grief on admission to the long-term care facility and grief at death, which require family and group therapy. Another issue identified was that of suicidal tendencies among the aging, including nutritional death as well as death resulting from failure to take medications. Other important areas considered include the problem of privacy, problems related to informed consent, and the issue of sexual segregation.

What little knowledge has been developed regarding

the problems of the elderly in minority groups has not been transmitted to those responsible for their long-term care, and there is great need for this type of information.

"RESIDENTS", "PATIENTS", AND "CONSUMERS": RIGHTS AND CONCEPTS

Throughout the Conference the words "residents", "patients", and "consumers" were used to refer to those persons who reside in long-term care facilities. Related to the use of these terms were subtle distinctions as to how the community, the administrators, and direct service personnel view the rights and concerns of older persons under their province. The difference in implication between patients and residents had been noted earlier. When elderly persons in a long-term care facility are viewed as consumers, they assume a role in the decision-making process which affects the range and the characteristics of the services they personally receive. Further, the social-psychological environment of which they are a part becomes more positive with regard to their own self-identity. This kind of participation reduces the status levels between providers and consumers as well as the use of the expression the providers so often level at the consumers—"these people".

In view of the apparent fact that most of those who receive services within the nursing home are "patients", and not "residents" or "consumers", a bill of rights for all was considered of great importance.

SPECIAL ISSUES AND NEEDS OF PERSONNEL

Throughout the Conference much discussion centered around the area of training. Should priority be given to the training of administrators or of staff? The consensus was that all personnel from the administrator to the paraprofessional in long-term care facilities should receive training.

The importance of attending to the mental health of staff was stressed, especially the large number from minority groups who offer first-line service to elderly residents. As Dr. Leonard Gottesman summed up the situation, (1) nursing home administrators often have little knowledge of the mental health requirements of residents and frequently do not give consideration to their responsibility to provide a way of life for people under their care; (2) the patients themselves find any existing personal problems intensified by illness and the imminence of death; (3) the staff are generally limited by poor education and pay.

From his study of such facilities in Detroit, Dr. Gottesman reported that the starting wage for paraprofessionals was a minimum $50 to $60 a week or approximately $1.80 per hour with a large percentage of staff providing the main support of their families. Inasmuch as such facilities are generally viewed as "the last resort" for employment, they are low status in the health-mental health care system. There is thus a need to increase the salaries and the status of personnel in long-term care facilities. Increase in status is related to providing released paid time for training.

It was also suggested that an important objective in the training of staff is to educate them to analyze their own feelings about illness and death with the hope that greater insight into themselves will help them understand their patients better and communicate with them as persons. Noted, too, was the importance of understanding latent hostilities among residents and between residents and staff. Here the role of the psychiatrist as a consultant to the staff can be most valuable.

EDUCATIONAL RESPONSIBILITIES OF THE PROFESSIONS

Other Conference participants pointed out that in most schools of medicine little is offered in the area of geriatrics. There is a need for the American Association of Medical Colleges to meet on the matter of curriculum in aging in medical schools. It was further recognized that most professional schools also have done little in the area of aging until recently. As a result, it is difficult to provide professional leadership in either aging or the mental health components of care.

WHOM TO TRAIN

It was agreed that the need for knowledge and skills to work with the aged applies to the mental health as well as to the long-term care field. Though community mental health centers have not traditionally serviced the needs of the aging, they could enter into a continuing relationship with long-term care facilities through joining sponsorship of continuing education programs. It was noted, therefore, that consultants be trained in the area of mental health of the aging to assist long-term care facilities to identify ways through which both administration and staff may better respond to the mental health requirements of elderly patients.

It was also pointed out that there is a need to train not only administrators and staff but, as a first step, "train the trainers", all of whom must be knowledgeable in the areas of aging and mental health as well as aware of the multifaceted problems faced by homes in caring for their residents.

In the United States there are more than 18,000

long-term care facilities, the majority having 40 beds or fewer. Most of the administrators of these facilities are not educated beyond the high school level and the personnel have scanty education and receive minimal wages. The result is a high turnover of workers. Although almost all are federally subsidized for patient care, the greater number of these homes are proprietary. Attempts to upgrade services through education in these facilities are often viewed by administrators as threats to their control.

It was suggested that the approach to education within the home should be two-leveled, on one level the administrators and on the other the primary care staff who are in direct contact with the residents. Training must focus equally on both groups, with leadership provided by mental health centers as well as through university-based programs.

A good precept to follow in the training process is to start where the students are. If the education of the staff is limited, basics may be prerequisites with the inclusion of information about aging and mental health. Further, it is important to consult with the trainees about their perceived needs and priorities. Since many of the first-line personnel come from various ethnic backgrounds and minority groups, vocabulary may be of primary importance.

In summary, then, mental health personnel—"the trainers"—must be educated in aging as well as in the unique concerns and problems facing both administrators and staff in long-term care facilities. Administrators must be trained to recognize their role in relationship to other staff and must provide the climate for growth and development as well as acquire knowledge on the subject of the mental health components of care. Further, they must learn to identify and use the mental health resources of the larger community. Staff training is a critical need; attention must be given to the special backgrounds and concerns which staff bring to their responsibilities, and training must begin where they are and not where the trainer thinks they should be.

THE PLACE OF CONTINUING EDUCATION IN LONG-TERM CARE

It was recognized that, although continuing education is an issue in long-term care and the responsibility of each level of personnel, there is often a lack of continuity in continuing education. Therefore, it is important to identify a responsible, coordinated structure for the continuous provision of training programs and to develop it through the resources of existing institutions, including universities, four-year colleges, and community colleges, and long-term care facilities with training programs. Further it would be important to work with state departments of mental hygiene which are the portals to viable means of changing the system of long-term care. One participant indicated that the need exists for a consortium focusing on training the trainers.

It seemed feasible that, to assure continuity of training programs, the model of the American Medical Association's regional conferences in long-term care be adopted.

RESOURCES

From the beginning of the Conference it was recognized that no one profession or discipline can adequately respond to the multifaceted needs of long-term care for the elderly. Therefore, it was suggested that traditional university training which tends to be uni-dimensional—that is, within a profession—must be reconsidered and broadened along interdisciplinary lines. Thinking should be geared to the creation of multi-centers carrying out multiple functions and responsibilities. Curriculum must be planned by a multidisciplinary team for an interdisciplinary (or non-disciplinary) approach to the provision of service. Bridging theory with practice requires strong linkages between educational and service resources. Moreover, in non-profit facilities governed by boards, the latter should be viewed as resources and as a means of linking the facilities with the community. A further important consideration is the role of the facility in the community in which it is located. For example, out of the Philadelphia Geriatric Center, which has a Director of Education and offers training beyond its walls, grew the concept of "package training" offered by institutions with major resources to other institutions and through this process developing new trainers.

Another important resource, alluded to previously, is mental health centers as well as mental health personnel in the community. The administrators must reach out and identify the mental health resources in the communities in which they are located. This is a communications issue which must be resolved. Further, for the majority of administrators, there is little sophistication in the areas of psychology or psychiatry. It was suggested that through administrative leadership and a commitment to training on the part of the administrator, staff turnover could be reduced.

Resources were then reviewed to include the university, the four-year college, the two-year college and professions which could provide continuing education; however, these must be offered within a multidisciplinary framework with an emphasis on interdisciplinary teams. The importance of combining mental and physi-

cal health in our approaches to training as well as in service provision was raised with a suggestion that multidisciplinary approaches must be related to disciplinary practice. In the area of mental health, we must recognize the need to expend resources for the aging, including mental health centers and related facilities. Institutions which have large resources and commitments to research and training should also be considered as practical resources to reach out to smaller long-term care facilities and to offer training leadership. Finally, the facilities themselves, including administrators, staff, and the consumer-resident are critical resources. Trainers can learn much about what the content of training should be from the viewpoint of and knowledge about long-term care requirements from administrators, staff and consumers. In addition, the families of residents must also be viewed as consumers as well as resources to continuing education programs.

EVALUATION

At the beginning of the Conference, the question was raised as to how we know whether what we do is what we should do. Although not a major focus of the Conference, there was some attention given to the critical and important role of research and evaluation.

The Conference closed without any major decisions or conclusions. The goal was to begin building bridges to bring together from regions throughout the United States major educational and mental health resources for the providers of long-term care for the elderly, and the discussions did open up new vistas of future possibilities. The goal, which still remains before us, is to improve the quality of care—the quality of life for those elderly persons who are residents of long-term care facilities throughout the United States.

Hobart Jackson is Administrator of the Stephen Smith Home for the Aged in Philadelphia.

The Concept Of Wholeness In Long-Term Care Facilities

By Hobart Jackson, M.S.

AS I review the perspectives presented in the three papers which follow, I am reminded of the point of view of Dr. Maurice Linden, a noted Philadelphia psychiatrist in the field of aging.

Dr. Linden has this to say about a philosophy of care: "The newer philosophy that underlies the development of modern programs [in long-term care] stems from the recognition that older people arriving at the province of seniority in need of institutional management are individuals who have already been victimized by a variety of forms of starvation—emotional, social, nutritional, economic, medical, and surgical. Should their hungers go unappeased, they tend to proceed into a state of personality inaction which may be thought of as emotional malnutrition. Such chronic deprivation is a destroyer of individuals."

I certainly agree with the implications in this quotation from Dr. Linden that our primary attack on the mental health of the elderly in need of long-term institutional care must start with doing more to improve the situation that exists with reference to the elderly outside the institution in the larger society.

The modern and progressive long-term care facility has long since realized the necessity of reversing and correcting undesirable social trends that promote the deterioration of older people if indeed its program is to be effective.

In many respects the long-term care facility is expected to undo the ills of the social environment by providing a corrective atmosphere for its older residents. Instead of perpetuating the inhumane and inequitable attitude of a dispassionate society, it must become the ideal society, making available to the older persons within its confines what is missing in the outside world.

Although the attention of the nation has been called this year to the unfortunate situation of many elderly in nursing homes and homes for the aged, much of the criticism has been directed too exclusively at the inadequacies of the long-term care institutions themselves. Greater efforts should be made to reconstitute and revitalize a system rendered inadequate largely by limited and unimaginative government programs.

Among the problems that should not be overlooked is that of minority groups. In the first place, it is far more difficult for blacks and other minorities to be admitted to nursing homes than it is for whites. They remain in their own homes without services or are herded into a public facility, usually substandard. In general, church related homes are not admitting their minority members, and the relatively good proprietary ones are too expensive for blacks and other minorities to afford.

To combat this situation I conceive of the development of 50 to 100 bed multiservice geriatric centers in minority communities providing both institutional and non-residential services, relating their care and services directly to the needs of the inhabitants, always involved, and serving both the affluent and the poor.

Another special problem concerns the employees of nursing homes, especially at the aide level—those persons who offer direct services to the elderly. They cannot be expected to communicate a "wholeness" concept to residents and patients until they themselves are in a position to embrace such a concept. Someone has well said that we often speak of the philanthropy of the rich but we seldom hear of the philanthropy of the poor. Most of our nursing home employees work in situations and for wages that represent "coerced" philanthropy on their part.

We agree, I hope, that wholeness is a goal for every

resident and patient in their effort to reach full potential for living and to sustain good mental health. But it is a goal for those serving as well as for those served. The provision of services demands not only competence and skill in a particular profession but enormous amounts of patience, forbearance, and insight into those things that tend to be fragmenting.

Sometimes the concept of wholeness may be endangered by a person, especially an aide, who simply is not well-qualified to do his or her job. Employees must be so well-trained, primarily through in-service-training programs, that they will never feel that they are being criticized for failing to do what they were not trained to do in the first place. When a person is not given the opportunity to take pride in his or her work because of peonage wages or impossible working conditions, he or she becomes less than a whole person, and this is a barrier to his or her communicating or sharing a wholeness concept.

The three major presentations which follow describe the nursing home as it now is and projects it as it could be; describe mental health components in long-term care; and discuss the potential vitality of continuing education to provide for the understanding and incorporation of positive mental health attitudes within a nursing home.

An Examination Of Mental Health Principles And Techniques

By a Psychiatrist, an Administrator
and an Educator

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Concerning Decent Institutional Care

By Dr. Robert N. Butler

IN the book I am currently engaged in writing, entitled *Mental Health in Old Age*, I try to deal with the whole range of mental health specialists, a group which in current thinking is no longer limited to psychiatrists and social workers. I believe that professionals in the field should abandon some of the hierarchical status-consciousness that characterizes their attitudes and make every effort to work as a team with paraprofessionals in terms of financial as well as other forms of equality.

The question of finances is always paramount. It is worth noting how little money the National Institute of Mental Health spends on aging, less than three percent of its budget, not only in terms of training, a fact already noted by another speaker, but in terms of research and of services as well. How desperately we need a center to provide a programmatic basis for some real teaching throughout the country and how very much we need to encourage medical school deans, nursing school deans, social workers and paraprofessionals to get their heads together in order to organize a crash program in education. I am reminded of Dorothy Moses' fine paper of some years back which analyzed one hundred-fifty baccalaureate nursing programs and showed how little attention they paid to chronic diseases and to old age, a situation I suspect is still sadly true today.

The role of a psychiatrist in a nursing home or similar institution is really quite minimal, and I can no longer honestly make distinctions between nursing homes and mental hospitals, since there is almost a fifty percent chance that the mental patient might be in either. As the works of Bernard Stotsky and others point out, for example, the more submissive, the meeker are transferred from state mental hospitals into nursing homes and foster care institutions, being more tractable and therefore more acceptable. But some curious and interesting characteristics of the flow of patients from one type of institution to the other indicate that ultimately an innovative type of institution may emerge and move beyond itself into the community. This would have outreach and multiservice components. I would like to hope, and forgive me, members of the American Nursing Home Association, that it may ultimately take on the framework of a social utility. At the turn of this century, we moved from proprietary to non-proprietary hospitals. How soon will we eliminate the idea of profit from care for the aged and begin to deal with social utilities?

It is extraordinary to realize that by 1975 there will be more patients in nursing homes than in hospitals, and we now have a million in nursing homes. That represents a great deal of money. The nursing home industry is subsidized largely by you and me as taxpayers, two-thirds of it being financed by federal money. It draws on state money as well. Yet we as professionals constantly have to compromise ourselves because, even with the great expenditure of money, we are unable to provide the kind of care we wish to give.

In 1958, when I first became associated with nursing homes, such institutions might conceivably have a nurse but would hardly qualify under the endearing term, home. Now there are more nurses than there were then but not enough, and we are still confronted by a number of unanswered questions. What do we expect to find in a nursing home? Will there be a social worker? What about the time when the patient's benefits under Medicare are used up? Who is to help the family place the patient at that point? What about the psychiatrist? How often are his services, or the services of any mental health specialist, called upon? Mine are sought very rarely. And yet nursing homes are dealing continuously with very disturbing problems of the aged—separation, anxiety, and shock.

People in general sympathize with the phobias, anxieties, and fear of separation that a five-year-old child experiences when he first starts school. Yet the same kind of people are insensitive to the similar problems of the elderly thrust suddenly into an unknown, lonely world, particularly since we know from scientific data going back as far as 1945 that transfer often results in morbidity and mortality.

In a nursing home there are two types of grief, the first, admission, which so deeply and profoundly affects the family, and the terminus, death, which occurs on the average of 1.2 years later. So family therapy is very important, as is group therapy in working with relatives.

I assume that this group, within the next few days, will be dealing with the development of innovative ideas. I would like to say a word about decision-making. The civil libertarians become very exercised about our mental hospitals, about the fact that people should not be railroaded into them, and that commitment procedures should be very cautiously employed. I agree with that. But the same civil libertarians, good friends of mine here in Washington such as Charles Halpern from the Center of Law and Social Policy, seem less aware of the assignment processes to nursing and foster homes where I dare say there is less concern for patients' rights than is found in mental hospitals. It is crucial that we allow—not just allow but give to—families and to the older person himself or herself the right to participate in the decision of admission to whatever institution may be in question. Then there is the second legal right—the right to treatment. One of my great regrets is that the American Psychiatric Association has declared against an enforceable right to treatment. The deputy medical director, two months ago in Montgomery, Alabama, again spoke out against enforceable right to treatment, in Bryce State Hospital, Governor George Wallace's Alabama, where people get fifty cents a day for food. I feel that in the matter of the right to treatment we must move to the right, which means, of course, the right to active care, not only in mental hospitals but in nursing homes, foster care homes, and other institutions.

While we are discussing the question of decision-making, we have to remember a characteristic of many old people—the suicidal tendency that many of them reveal. When this is overt and the person is considered a danger to himself or to others, he is, in most states, committed to a mental institution. But many times this death wish is undetected because it manifests itself in subtle ways. The person may, for example, seek death through a lack of nutrition or of medicine. He may simply refuse to eat or to accept medication, or he may find other ways of destroying himself. In such cases the subtle efforts of a mental health specialist may be able to reveal the suicidal intent though he might find it extremely difficult to get this across in any court of law or through any legal commitment procedure. This is something we should begin to understand.

Many things must happen as far as nursing homes are concerned. The first is that it should become more like a mental hospital—that is, it must have the best features of a mental hospital. The mental hospital of the future, I hope, will not be a massive, cold place as most of them are today. My proposal for St. Elizabeth's Hospital here in the District of Columbia illustrates what I have in mind. I see it broken up into smaller units and distributed geographically throughout the city. There should also be a geographical distribution of state mental hospitals and a profound questioning of present zoning procedures which reflect real estate interests rather than human interests and needs.

To facilitate family visiting the institution should be relatively near the patient's home. In Washington, for example, relatives may have to travel to suburban Montgomery or Arlington counties to see someone quite dear to them, and even the most devoted families might sometimes find this difficult to do.

Regardless of the type of institution to which the aging person is admitted, his physical condition should be diagnosed and an individual program of treatment prescribed in no more than twelve hours after his admission. No cardiologist would accept what psychiatrists accept in the way of inadequacies of diagnosis in the formulation of treatment programs.

It should be assumed that patients in our nursing homes live in an atmosphere of personal safety and security. Unfortunately, this is not always so. Outbreaks of salmonella frequently occur, and there are frequent deaths from fire.

We need to have more protection of the patient's money. There are many reasons to believe, from studies made in Missouri and elsewhere, that public assistance payments and other small private funds patients have in nursing homes are not protected. They fall into the hands of the foster care sponsor or nursing home owner and, unfortunately, are often not spent for the benefit of the patient.

The rights of patients cannot be conceptualized in abstract lovely terms as "dignity" only. We have to talk about them in real terms: life, personal freedom. Patients should have twenty-four hour visitation rights. Families and friends should be able to visit at any time, any time of day. Unannounced visits by standard-enforcement bodies should be in order. A well-run institution should be open for inspection at all times, should have nothing to conceal.

Too, we should take a profound look at the uses of

medications. Though tranquilizers are effective ways of calming the nerves of those who run the institutions, they rarely benefit the patient and often form a kind of chemical straight jacket. As the works of Crane and others indicate, the use of phenothiazine, of the thorazine type series, produces tardive dyskinesia. This is very serious because, even after the discontinuation of this medication, patients develop sad and profound muscular and other types of disabilities in significant percentage, some resembling Parkinson's disease, which are frequently accepted casually as conditions concomitant with old age.

On occasion I have been a minor hero (though I understand this is the period of the anti-hero) to families when, called in for consultation, I simply removed the patient from this type of medication with the result that the patient recovered. I cite as an example the case of an older woman who had been admitted for a cataract extraction. Since she was tense and nervous, the opthalmologist quite properly put her on thioridazine (Mellaril). After the operation her confused condition was diagnosed as stemming from a senile brain disease. Sent to a nursing home, she did not improve until, having occasion to see her during a consultation, I took her off Mellaril and in a short time she was a perked up young 70-year-old.

I propose the following as necessary components of decent institutional care:

Patients in long-term care facilities should have their right to privacy protected. They should give informed consent to any medication the physician prescribes—they should not be victims of experimentation. The facility should have a true medical faculty, responsible for and accountable to the residents. The case in Baltimore a year or year and a half ago in which the physician eschewed responsibility for the patients, should never be duplicated.

Work therapy programs should be freely accepted by the patients and carried out under the Fair Labor Standards Act and Work Shelter programs.

The realities of sexual need must be taken under consideration. Sexes should mingle in long-term care facilities. At Chestnut Lodge where we had such a program the patients received a lot of pleasure. Masturbation should not be relied upon as the only sexual outlet for the aging.

Nursing home architecture must give the elderly resident a true sense of security. Such buildings should not be built as if the aim of the owner is to transform them into motels if necessary.

Residents of nursing homes should have the right to raid the refrigerator at any time. I see no reason for assigned snacks.

I realize that many people may consider the above suggestions impractical. But there comes a time when the only practical solution to problems are seemingly impractical types of innovative thinking to begin to break down some of the anxiety, some of the anger, some of the grimness, some of the emptiness which we find in our institutions, some of the benumbing conditions which make the aging person appear more difficult than he actually is.

Herbert Shore, Director of Golden Acres in Dallas, Texas, is an exponent of such goals and certainly his efforts to eliminate authoritarianism in institutions is important.

Patients should have a voice in their own government. I have been struggling to encourage various sectarian homes in the District of Columbia, for example, to have older people, really older people, on their boards of trustees. Some weeks ago I had occasion to spend a morning with Ralph Nader and the new group, the Professional Retired Action Corps. Among the proposals made at that meeting were that older people in various cities become evaluators of nursing homes, free to walk in day or night without having to wait for formalities. Because the innocent are usually aware of deficiencies in their surroundings, and older people certainly have a stake in what is happening in nursing homes, we encourage them, as observers, to move directly into various types of nursing homes and other facilities to see for themselves.

Comprehensive diagnostic evaluation is necessary. We must be particularly alert to those conditions which are treatable, and which often go unrecognized, such as reversible brain syndromes which may be due to malnutrition, shockingly common among older people, or to anemia, or to congestive heart failure. We must be aware of the so-called functional disorders—depression and paranoid states, which can be treated though they cannot always be diagnosed without trial treatment. Frequently it is in the course of treatment that the diagnosis becomes apparent. For that reason, there is need to have within our cities reception centers, places which might be called emergency centers for brief admissions where mental and physical conditions can be diagnosed, where there is time for the necessary decision-making that may involve the medical doctor and the neurologist, the social worker, the nurse, and others, where one can really build upon the work in preadmission screening, a movement started in San Francisco and conducted in Baltimore, Philadelphia, and elsewhere.

It is important, of course, to introduce this concept into both our private voluntary and public municipal hospitals from which poor people are often turned away, Medicare patients included. The quota system operates

here in the city of Washington. For example, the largest hospital, the Washington Hospital Center, acknowledged to me, as chairman of the Mayor's Advisory Committee on Aging, that their quota is ten percent. This means that the patient without a personal physician will be dispatched to D.C. General Hospital, already overloaded by the dumping syndrome from so many of the voluntary hospitals, even though voluntary hospitals are direct recipients of tax-favored dollars.

We need to recognize the enormous success of private mental hospitals in order to remind us how money does count. According to the studies of J. M. Myers of Philadelphia, Robert Gibson of Sheppard and Enoch Pratt, of the some 110 private mental hospitals in the United States a surprising 60 to 70 percent of older patients are out of the hospital and back in their homes within two months after admission. Again we have to remind ourselves of the need to make some profound commitments. What can be done about the elderly whose families cannot afford the expensive care provided in private institutions where bills run as high as $1200 or more a month with all the additional costs above the basic fee?

At this point it is important to face the reality of chronic illness in the United States. This constitutes two-thirds of the cost of health throughout the country. In 1970 the cost of health care was 70 billion dollars, two-thirds of which went to chronic conditions. None of the national health plans provide adequate coverage for long-term care, chronic disease care, terminal care, or psychiatric care.

We cannot move nursing home patients out of the main stream of American medicine, using the concept of medicine broadly to include its social and other components; otherwise, how can we learn from research something about senile brain disease and arteriosclerotic brain disease, so costly both in personal suffering and to the nation as a whole? We cannot tolerate a continuation of the present system under which medical students seldom go into a nursing home. We must begin to change this. We cannot change it if we transfer all older patients from mental institutions to nursing homes and foster homes. Such an experiment was carried out recently in the District of Columbia. From the best count we have, 650 mental patients from St. Elzabeth's more tractable patients were moved, not into nursing homes or personal care homes, but into so-called foster care homes, a term which originally dealt with the care of children. The foster-care sponsor received $125 a month, which is about $4.00 per day, and the profit had to come off the top. One day Mr. Philip Rutledge, Director of Human Resources, and I made a round of visits to foster homes. As a result of what we saw we became physically ill. In some of the homes no sponsor was there to greet us. In others we found patients with medications like stelazine, one of the causes of tardive dyskinesia in their own hands, hallucinating, confused, clearly people who should not have been left unprotected.

We need very much to question procedures in nursing and foster homes in a great many states—Tennessee, Illinois, others. Moving the elderly into nursing homes is sometimes literally moving them from the frying pan into the fire since basic fire security is minimal in many of them.

As inadequate as they may be, many mental hospitals have what most nursing homes lack—a kind of campus flavor. There are stores, churches, synagogues; there are dancing halls; there are many advantages not found in the community. And we have to be careful about that euphemism "community." If people who have been in a mental hospital for 20, 30, 40 years are moved from their familiar into unfamiliar surroundings, they are not being moved back to the community they knew before. Frequently they are not being moved into a safe community.

There are exceptions to this. In Philadelphia, for example, the program involving placing elderly persons in foster homes was not the disaster it was in Washington, D.C. so I am not trying to make a general indictment of that type, or other types, of care. In fact, I feel very strongly about the importance of a whole range of alternative types of care. But we must not delude ourselves with some of our own terminology. For example, to speak of the foster care home as a "community" and the mental hospital as not being a "community" is a curious circumlocution. Why should not the mental hospital become part of the community in the proper sense of the word? But we know from zoning regulations in most cities and states that there is opposition rather than interest in having nursing homes, foster care homes, any type of personal care homes in the "community" at all. In that area we must do some very serious thinking.

There are some new ideas to be pressed, many things that can make it possible for older persons to remain at home, or contribute to the prosthetic environment of an institution, providing techniques that match the deficiencies the individual may have—in hearing and in ambulation, for instance, I cite as an example electronic devices such as remote control.

If we do not begin to move in those directions, our present efforts, however well intended, will remain essentially meager. The work of Robert Morris in his Brandeis University study on the extent of need of alternative care, suggests the personal care corporation composed of individuals who will provide a range of

human services. It is imperative that if a physician is going to practice medicine honorably and appropriately he must have the names of substandard nursing homes and similar facilities in his area. This is the kind of issue worth raising—the very important need, as part of our effort, to be politically aware. I do not mean political in a partisan sense but in the sense of being conscious of both public policy and clout in a city like Washington.

I suggest that the American Association of Medical Colleges be persuaded finally to introduce geriatric medicine into the curricula, and finally have medical students actually see chronically diseased patients by visiting nursing homes. I would like to suggest, too, that we take more seriously the problem of racial segregation in homes for the aging, especially in sectarian institutions where fewer than three percent are black and the percentage of Latin Americans and Asian Americans is minimal. We need a practical ecumenism in which the resources of various groups and institutions are shared. A church-sponsored institution alone, for instance, might not be able to afford a social worker but a group of institutions sharing resources can.

I think too that religious groups, which have made a great contribution over the years to institutional care for the elderly, must now move broadly into the community itself, beyond the walls of the institution. In saying that I have, I think, come to a full circle. I come to the end with emphasis on the need for a continuing fluidity between the community and the institution so that one eventually fuses with the other so that a multi-purpose center emerges which has outreach, which provides legal services, which has residential features, to which the admission process is brief and evaluation and treatment effective so that we can truly begin to meet, as we must, the needs of older people who ultimately, of course, will be all of us.

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Continuing Education In A Long-Term Care Facility

By Arthur Waldman

THE original charge, when I was asked to participate in the National Conference of the Gerontological Society on Long-Term Care for the Elderly, was to develop and present a framework paper to assist in developing models for continuing education in mental health for personnel in long-term care facilities.

I cannot isolate the mental health of the personnel from the totality of the facility. The term "mental health" concerns everyone connected with the operation of a long-term care facility from the governing body through the administrator to the paraprofessionals and their interrelations with the patient and/or resident.

Basic to any continuing education program is the need to examine the reasons why an administrator has such a program. Is it because the state makes it mandatory or because other agencies have this kind of activity? Is the training program confined to nurses' and some staff meetings? What are the contents of the curriculum? "The ecologist does not look to see what is in the field but rather what is going on," wrote Dr. Robert Maxwell in "Human Ecology: Overview of Man-Environmental Relations."

An excellent measure of any continuing education program is to assess the investment made by the administrator. Does he expend monies for this effort? Does he spend money for a full-time or part-time director of training? He may do neither, though he may for a dietician because it is legally essential. Does he provide money for his staff to attend conferences and meetings? Does he make money available for tuition to further professional growth? Does he allow staff time and money to attend professional meetings? Does he find money to bring in consultants?

The administrator must be a living part of the operation of a long-term care facility; he must be the glue that holds all the parts together.

Much attention must be given in continuing education to the subtle features of care that make for good mental health. The institution that emphasizes the physical plant and the externals of care while invading the privacy of its residents has failed its commitment. For example, a mirror on the bedroom wall is certainly a more effective instrument in achieving better mental health than a fully equipped clinical laboratory.

I urge those of you who will be constructing models of continuing education in long-term care facilities to emphasize those factors that effect normal, healthy interpersonal relations in the community.

Mental health in a long-term care facility is a multifaceted problem. We need to concern ourselves with the mental health of patients who present no psychological problems. For this group we must have programs and staff that are committed to maintaining an atmosphere of normalcy (as much as can be maintained in an institution). We must also concern ourselves with patients who show signs of mental impairment. This group needs specially developed programs and staff for their needs. Equally important is the mental health of the staff since the success of any program depends on the skills, commitment and understanding of those who run it.

Cartwright in *Human Relations and Hospital Care* writes, "Patients' comments on the way they are treated as people are relevant to any general evaluation of the hospital service. Their comments are important not simply as an index of consumer satisfaction... but because effective medical care depends on patients' attitudes and cooperation." Francis, Korsch and Morris in "Patients' Response to Medical Advice" (*New England Journal of Medicine* 280:535, 3-6-69) report that there is a significant relationship between patient satisfaction and compliance with physicians' instructions.

There is much additional material in the literature to support the fact that patients' satisfaction and/or mental health has much to do with their physical status.

Esther Lucille Brown in *Human Dimensions of Patient Care* stresses the need for staff to understand the requirements of the patient that are other than physical.

Goffman in his book *Asylums* refers to the patient world and the staff world. When there is no attempt to bring these worlds together, the results are poor care.

How then do we effect the best level of mental health both for staff and patients? The answer to this question on the surface appears relatively simple—namely, maintaining a healthy relationship of staff with staff and staff with patients as well as patients with patients.

How then do we cultivate such relationships? Obviously the administrator's attitude is of prime importance. Though his contacts with staff and residents may be limited, it is apparent that a program of continuing education keeps open his line of communication and communicates his concerns at all levels.

Underneath the surface relations within a long-term care facility, however harmonious they may seem, tensions stemming from the private lives of staff may interfere with their relations with the patients. Therefore, administration, social service and medicine should be prepared to assist staff with their personal problems when called on. Inasmuch as the patient relies on the delivery of service which represents a diversity of training, education and background and each department of necessity has its own loyalties, all too often inter-staff conflicts arise. The failure of one department to understand the importance of other departments can cause an impairment of administrative mental health of an institution. This can result in the lowering of the quality of patient care and hence the mental health of all parties. A glaring example of such a situation is described in the book, *The Life and Death of a Mental Hospital*, by Ezra Stotland and Arthur Kobler.

For the effective working of a long-term care institution we must accept the first principle of education—i.e., "adjustment and progressive readjustment" to improve one's own situation—and combine it with the Socratic definition of an educated man—one who understands his fellow man and conducts himself in an honorable fashion.

The foregoing gives our rationale for the imperative need for continuing education. The basic skills of the personnel of a nursing home, whether they be medicine, nursing or social work, were acquired in other settings and were general in nature. Now all are faced with a highly specialized group requiring new understanding and in some instances new approaches.

I will not burden you with the details of the training program of the Philadelphia Geriatric Center but will merely list them to give some idea of scope and concern.

In our effort to interest and assist in training of other groups we have a social work student unit consisting of four students and a supervisor from the University of Pennsylvania School of Social Work; students from Bryn Mawr, student nurses from Pennsylvania Hospital, Temple University School of Nursing and other schools of nursing; medical students from the Medical College of Pennsylvania and Temple University, and mental health worker trainees from Temple University.

The following is a brief description of the continuing in-service training programs:

Nurses meet and are instructed by other nurses, physicians, social workers and social scientists;

From time to time members of the research staff meet with the nursing staff to gain insight into the problems of each and to be of mutual assistance in solving them;

Administrative staff meetings are held regularly to keep department heads informed of new developments;

Medical staff meetings are held regularly as well as conferences with all staff concerned attending;

Visiting lecturers are brought in to speak to staff on their programs on new developments;

At least once a year the Center sponsors a center-wide program inviting other groups and individuals to participate.

Mindful that the essential quality of education is communication leading to better understanding, the Philadelphia Geriatric Center set up a program in which staff meetings were held on a monthly basis for a year to discuss the mentally-impaired aged. These sessions called for each department head to discuss the problems he encountered in dealing with these patients and contribute the insights he had received in solving them.

In short without a program of continuing education, communication among the various levels of personnel and residents becomes garbled with resultant misunderstandings; in turn, these breed stagnation and lack of mutual concern.

In conclusion, I would stress the fact that, without a program of continuing education, a long-term care facility can only be ineffectual and its personnel, like so many Sisyphuses, rolling stones uphill to no avail.

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The Educational Experience And The Role Of The Educator In Training For Long-Term Care

By Jerome Hammerman

MENTAL health and mental impairment are broad terms. Activities associated with their promotion or prevention can involve the function of individuals, masses of the population, and people from many different disciplines. A multiplicity of systems of thought and a range of methods of intervention, as heterogeneous as the individuals, groups and disciplines concerned, are involved in working on the challenges presented by these efforts.

In a recent report by the Group for the Advancement of Psychiatry, "The Aged and Community Health: A Guide to Program Development," a number of conceptual models were suggested for both describing causative factors of mental impairment and intervening to control its incidence on a community-wide basis.

There is strong evidence to suggest that, whatever the etiology of geriatric mental illness, it is susceptible to treatment and, further, that geriatric patients are able to benefit from rehabilitation programs designed to help them get well or to live with their incapacities. Moreover, there is growing consensus that a custodial environment inevitably results in further deterioration. Indeed, increasingly, we find ourselves stressing, in theory, if not always in practice, non-institutional services as against twenty-four hour care programs. The direction appears to be one of expanding community responsibility, although usually without making available either the resources or authority commensurate with the responsibility assumed by or imposed on community agencies.

Institutional programs, according to Gottesman, appear to work well when they can establish a therapeutic environment, one which presents a series of "graded life crises" to be worked on in a protective setting. The impaired coping ability of the person is, hopefully, enhanced through opportunities afforded him to confront and deal with meaningful life crises. Community programs, more often, focus on after-care, prevention of, or arresting mental impairment.

In all our approaches we need still to widen our knowledge base and to engage in system-changing activities that permit us to redirect resources in planned and productive channels. We need personnel in this field, in other words, who can add to our knowledge, engage in effective social-health treatment roles, and serve as change agents as well. Practice, as so often happens, tends to lead the way. But practice and formal education are indissolubly bound together. Present curricular models no longer suffice, so that changes are essential if professional training is to be effective and be affected by a developing practice. In this respect, a new ingredient has recently been added.

A strong push to "deprofessionalize" and draw populations into the mainstream of human service activity is both the order of the day and the rallying cry of the young. Can this ideology be extended to our work with the mentally-impaired aged? And with what consequences for both clients and professional community? The "citizens' movement," generally, has ranged broadly in the areas of education and of poverty, but it has rarely targeted in on the mentally-impaired elderly. The hope is that the future will see more community effort directed to this group of "social lepers."

Furthermore, inadequate financing, mounting costs and manpower shortages (or maldistributions) virtually

mandate that new forms of professional utilization must be attempted by those involved in education for long-term care. Stress must be applied to altering negative community attitudes and overcoming professional resistance, or at best reluctance, to becoming involved in this area of human service.

The trend is in the direction of comprehensive care centers capable of organizing, controlling and delivering a broad range of interrelated social and health services. Critical to this concept of service delivery are the comprehensiveness of the program and the delegation of responsibility. No longer, for example, can the referral or transfer of patients, with all its attendant psychological problems, be left to the whim or caprice of independent elements in a service system. Nor should we tolerate vested, special interest groups dictating social policy. Fragmentation, over-specialization and resistance to change as they presently exist in training programs and operating agencies represent major blocks to improved programs for the mentally-impaired older persons and will need to be addressed more robustly.

The purpose of this meeting, however, is not to recount existing educational deficiencies (an easy enough job to do), but rather to develop a framework for their identification and strategies for their resolution. I will make a few observations, then, and pose some questions that seem important to me. Lest we spend our time reinventing the wheel, however, it might be helpful to glance back at some critical observations that have been addressed to this issue.

In their report, "Toward a Public Policy on Mental Health Care of the Elderly," the Committee on Aging of the Group for the Advancement of Psychiatry suggested guidelines that ought to prevail in training programs. Let me recapitulate the key elements:

(1) *Medical Education.* Courses in human behavior and psychiatry should cover the entire life cycle and the life cycle concept should be central; non-medical specialists in human aging should be included in teaching programs; opportunities need to be developed for psychiatrists to collaborate with other specialists; greater emphasis in medical education should be placed on the treatment of chronic diseases, and teaching clinical experiences should emphasize the diversity or range of psycho-social care or settings serving this population; teachers should use every opportunity to demonstrate the challenges and satisfactions to be derived from treating the elderly and patients with chronic diseases—in the hope that the example of "respected teachers" is a most effective way to encourage young professionals to give high quality service to these groups.

(2) *Psychiatric Education.* The concept of subspecialty geriatric psychiatry should be rejected as both unwise and unfeasible. Rather, effective teaching, the inclusion of aged patients in teaching facilities, "therapeutic optimism," and the increasingly important role of psychiatrists as consultants to facilities and programs serving aged patients should be emphasized.

The GAP report proposed a major revision in the psychiatric curriculum in medical schools and in psychiatric residencies that, again, would stress the life cycle as the guiding context of concerns, and called upon the staff of the National Institute of Mental Health to assume leadership in gaining cooperation from the American Association of Medical Schools, the American Psychiatric Association, and other groups involved in such training programs.

Educational materials should be produced for public schools as well as for the medical professions, and guidelines should be developed for operating service programs that would involve educators, practitioners and researchers. NIMH was also encouraged to increase its special training programs in aging, particularly those dealing with clinical and community psychiatry. A special Training Committee on Aging was recommended as a viable means of increasing the number of training programs in various mental health disciplines.

(3) *University Schools for Health Practitioners.* It was pointed out that the full range of educational institutions and organizations will be required to take the lead in providing training for evaluation, care, and treatment of the mentally impaired elderly. The GAP report called for the establishment of "unique" university schools for health practitioners whose themes should be: community medicine, health services in an urban environment, chronic diseases and the use of the coordinated team approach. These schools should train and graduate health professionals ranging all the way from "personal care" workers down to physicians. In the process such an approach would, hopefully, clarify and optimize differing functions, utilize teaching time more effectively and in so doing systematically examine the delivery of services by way of outreach service teams. The vital components to be added are those of promoting career ladders and focusing attention on the "neglected" groups in society—the poor, the aged, the alcoholic, etc. This New Careers Component was further linked to the establishment of a National Personal Care Corps and the institution of a National Protective Care Program.

Finally, the GAP report stressed the need for an increase in health manpower both in numbers and in quality. The catalytic role of effecting changes in education, in community mental health centers, and in other similar programs should, they urged, be lodged with the National Institute of Mental Health.

In a paper prepared for a workshop on *Bridging Social Work Education with Practice for Aging* (1971), Walter Beattie observed that social work is going through a rapid, almost revolutionary change, replete with identity crises. This is true for all levels of social work tasks, from direct services, to the most complex actions associated with planning and policy development. The growing role of the two-year college as the prime source of training persons for specific and technical tasks is spreading, as are consortia among universities and colleges whose purpose it is to maximize the depth and quality of limited resources.

As Beattie pointed out, we are witnessing the breakdown of the traditional insularization of social work education in ways which will permit multidisciplinary and multi-professional teaching and learning. Nor is this shift limited to the field of social work. The health professions, generally, are ripe for such imminent changes.

Educators, whatever their discipline or the target population of concern, must essentially confront four questions: (1) What are the purposes of the program? (2) What learning experiences will attain these goals? (3) How could these experiences be organized? and (4) How can the program be evaluated?

What must the student in this field achieve, regardless of his place in the spectrum of care? Beattie answers it this way: "students must begin to perceive . . . ways of developing intervention skills, knowledge, and indeed, values which will relate to the promotion of function, the prevention of breakdown, and the treatment of the unacceptable throughout the life span. . ." Furthermore, "such intervention models must be able to translate from the individual case to . . . social policy levels." The "mutuality of practice modalities" (Brody) such as this field represents must find its counterpart in the educational experience that moves us beyond the uni-dimensional professional, to the "team," the group practice, the multi-professional role.

As our educational institutions are presently designed and programmed, the lead time required to produce needed manpower is probably too long. Re-evaluation of the present educational curriculum is essential in order to ascertain if it is indeed necessary. Can it be shortened to increase production without lowering quality? The medical field, and others, are seriously beginning to examine this question.

Another more promising avenue for improving our manpower is that represented by the growing importance of ancillary social-health personnel. For too long professional pride and jealousy, fear of competition and criticism of competence have restricted the cooperative arrangements that might have increased the efficient use of the skills and time of the more highly educated segments of the social-health professions. A breakthrough, however, will require mutual respect and understanding by all groups—as well as a shift in licensure codes and financial incentives. Such action requires a ruthless examination of professional functions to determine what new and significant caring roles might be possible for new breeds of workers.

Education in the human services should, it is suggested, provide the tools for adaptability to an ever-changing world. "Educate for change, but do so in an educated manner." Social work, for example, is committed to change that will humanize man's interaction with man and society and maximize his potential for social functioning. This means that the profession requires a wide range of modes of intervention within a broad spectrum of situations. Curriculum designs which aim at "knowing, feeling and doing," however, without precise specificity of meaning are almost certain to be unsatisfactory.

We have yet to develop a research based practice model for the training of social work students (and others) in community mental health settings. We also need to use and modify prevailing conceptions of mental health and gain a better understanding of the organizational context of (social work) practice, including the interactions between social workers and members of other professions.

It seems clear that most graduate social workers in local community mental health facilities are heavily involved in administrative, supervisory and training activities, and a considerable amount of direct service activity is carried by social workers without graduate degrees. Special education might be better structured so as to help students in the professions prepare for such multiple roles—e.g., as direct service practitioners, as supervisors of staff at the B.A. level, as in-service trainers of undergraduate personnel, and as program administrators.

One thing seems clear—it will no longer be possible to educate workers for the human services professions by way of self-contained, restricted, neatly labeled, totally independent and autonomous tags. The movement from "cottage industry" organizations to articulated services within larger combines, cooperative, or multi-functional agencies will tend also to diversify the necessary skills of those working in these areas. It will make it necessary to design opportunities for continuing education that intensifies, sharpens and deepens primary skills, as well as offering ladders for professional development that permit individuals to move both vertically and horizontally.

In the process, hopefully, we will not have lost the

baby with the bath water, i.e., the unique professional skills that are critical and instrumental. We cannot lose sight of the fact that education in this field is concerned with providing a basis for the student to:

(1) *Incorporate the knowledge, skills and values basic to this specific discipline;*
(2) *Recognize the social, cultural and political constraints and opportunities that modify the application of his skills;*
(3) *Anticipate human needs in a rapidly changing society and project new forms of programs or services to meet those needs;*
(4) *Understand his own helping role and contribute responsibly to the development of the program;*
(5) *Utilize, wherever possible, all forms of inquiry to advance knowledge and improve standards of care; and to*
(6) *Attain a level of competence necessary for responsible practice and sufficient to serve as a basis for a creative and productive career.*

Clearly the educators' role here is crucial. The "respected teacher" starts by establishing a commitment based on a rational view of the problem and proceeds to demonstrate this conviction by a willingness to confront traditional forms in both the university and in the operating agency. He is instrumental in developing programs for students that focus on the acquisition of skills *and* values. He works as a change agent himself within the educational institution and, to the extent that he can, in the community. What I am saying is that our plans for training mental health workers in this field will be meaningless unless the educator can influence others to modify curriculum, coalesce research interests to these ends, and restructure educational priorities. Both educator and educatee are bound up in this process of learning for doing.

In all this there is both danger and opportunity for those who would advance the needs of the mentally impaired elderly. In fact, the word "crisis," in Chinese, is made up of two characters which roughly translate to the words, opportunity and danger.

The prod to experimentation and change was expressed best perhaps by Alfred North Whitehead: "A civilization which cannot burst through its current abstractions is doomed to sterility after a very limited period of progress." Or as a simple man once put it—a bird in the bush may indeed be worth two in the hand.

Concepts And Training Techniques: A Variety Of Approaches By Participants

Participants in the May 14-16 Conference "Bridging Continuing Education and Mental Health in Long-Term Skilled Care for the Elderly" were asked in advance to prepare some material they felt would be helpful in designing educational programs for administrators and staff of long-term care facilities. The responses outlined critical issues, described various on-going programs, and proposed models to be implemented in the future. Though they offer a variety of approaches to training and to the psycho-social aspects of life in long-term care facilities, they share the same positive outlook. Institutional life in old age, they say in one way or another, need not be a series of days following meaningless days. They indicate that, as a result of continuing research into the physical and psychological facets of aging, all levels of staff in long-term care settings can receive deeper insight into the effects of institutionalization on the aged, and that this knowledge will aid them in offering more adequate and sympathetic treatment. They project the hope that consequently the last years of life can be richer and hence more rewarding. Those who themselves are responsible for training may find useful suggestions in the programs which the following statements describe.

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Concepts And Considerations For Building Continuing Education Programs To Improve The Mental Health Components Of Care For Residents Of Long-Term Care Facilities

**By Michael C. Alin, M.A.;
Professor Walter M. Beattie, Jr.,
Donald Boudreau, M.D.,
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THE mental health components of care for residents of long term care facilities must focus not on treatment modalities but on supporting and building functional capacities, particularly of the older person. This perspective implies that continuing education programs must take into consideration broad framework of roles, responsibilities, systems, and settings.

It also implies that in order to effectively be responsive to the mental health needs of older individuals, any continuing education curriculum must focus on philosophies and concepts of care; the relationship of such concepts and philosophies to individual attitudes about aging and older persons, including one's own; generalized as well as specific knowledge concerning its aging population, as well as specific knowledge about aging individuals and the skills required in working with them; and finally, the application of such knowledge and skills within the framework of attitudes, concepts and philosophies, as well as within the larger socio-political framework. This suggests one approach which follows:

Concepts and philosophies affecting attitudes toward understanding of older persons include recognition of the facts:

- *. . .that each older person has the right to self-mastery of his own person as well as of his environment within the limitations of his functional capacities;*
- *. . .that self-actualization and human development is a life-long process, along the continuum of time;*
- *. . .that societal forces and approaches to aging tend*

to denigrate, segregate and isolate older persons, increasingly taking away their rights to independence and interdependence;

. . .that social definitions of aging are not inherent in the biological or psychological processes of aging;

. . .that the right to choice and of options in decision-making is significant in the lives of all individuals and that society increasingly restricts the exercise of the right of choice in the latter stages of life;

. . .that there is a need to legitimize and make relevant the latter stages of life and their significance to the older person as family and society;

. . .that there is a need to recognize the increasing differentiation which occurs among persons as they grow older, requiring societal responses and services to the needs of older persons to be highly individualized;

. . .and that life is a continuum within which, at times, discontinuity occurs for older persons; it is important to understand and recognize that present responses and behaviors have roots in the past and that there is a need to bridge the present with the past, as well as to support older persons in responding to the present and preparing for the future.

ORIENTATION FOR ADMINISTRATION AND STAFF PROVIDING SERVICES TO OLDER PERSONS

Administration and staff providing services to the aging should set their service delivery goals in terms of the resident's functional capacity and areas of potential gain, not of merely his deficits and losses.

Administration and staff should recognize that the problems associated with aging are interdependent; services for older persons involve many disciplines organized on an interdisciplinary basis. (Housing needs are related to health status and functional capacities which, in turn, are related to good nutrition and diet—which has social and cultural, as well as biological, sustenance identities—which, in turn, are related to income and economic capabilities, and so on.

Administration and staff must recognize that their services are related to larger systems of service delivery, such as the health-mental health care system, the income maintenance system—Social Security, old age assistance, private pensions and so on. Older persons need help to negotiate such systems, including legal systems that affect property rights and civil rights (protective services). At times such systems, such as in the latter case, link social services, legal services and health-mental health systems of care.

LEADERSHIP PERSONS AS A FOCUS FOR CONTINUING EDUCATION PROGRAMS

It can be argued that it is imperative to address continuing education programs at the level of leadership persons (administrative and board) if change is to be effected in improving the mental health components of care among all levels of staff and personnel. These leaders might want to give consideration to the following areas:

A. COMMUNITY AND AGENCY CONTEXT

. . .Who forms public policy nationally, at the state and local levels?

. . .What is the local situation in terms of the provision of services?

. . .What kind of consultation is available? Are there public facilities and programs for all? Are individuals able to get third party payment for services and do they have freedom of choice as to where they receive services?

. . .What are the stated and unstated goals of the community and its principal voluntary (whether proprietary or non-profit) programs and facilities?

. . .What is the basic policy of the agency under whose aegis the facility operates? Is there an identity of goals among leadership people and are they ready to act cooperatively?

B. FACILITY CONTEXT

. . .Do the facilities reflect programmatic conviction about mental health? What is the mix of guests and patients? How are "mental health problems" handled?

. . .Is there a segregation by mental and emotional functioning?

. . .What types of convictions and commitments are there to in-service training for mental health preventive activity?

. . .How are mental health services obtained?

. . .How are these programs financed? Who takes responsibility for them?

PERSPECTIVES OF MENTAL HEALTH COMPONENTS OF SERVICE

Mental health components of care may be viewed according to the concepts of Gerald Caplan including

those of primary, secondary, and tertiary prevention. Primary prevention relates to the broad needs of older persons living in the open-community, such as money, medicine, mobility, and meaningful relationships, to mention a few. These suggest the need for services related to public education and consultation with agencies which can provide for the above. Secondary prevention focuses more on the needs of older persons living in confined settings, including their own homes. Here there is need for rehabilitative and supportive concepts of care and services, including home visits, reality orientation, therapy (re-socialization), etc. At the tertiary prevention level the focus is much more on the aging populations within congregate and shelter care facilities, including state hospitals and institutions where there must be an attempt to decrease morbidity and rehabilitate to higher levels of functional performance.

SUGGESTED ELEMENTS OF CONTINUING EDUCATION TRAINING PROGRAM FOR ADMINISTRATORS, PROFESSIONAL PERSONNEL, AND LAY LEADERS OF ADMINISTRATIVE BOARDS IN AGENCIES PROVIDING LONG-TERM CARE FOR THE AGING

It has been suggested that training needs of those responsible for mental health services for older persons in long-term care facilities include more complete knowledge of and greater sensitivity to the entire scope and range of conditions and problems of the aging; changing technical knowledge regarding mental health services for the aging; the system of services available to meet varying mental health needs of the aging; resources and conditions affecting the delivery of such services to the aging; relationships between the agency or facility and other facets of the social system, local and national, which affect mental health care for the aging.

One training model which might be appropriate for meeting such needs on a large scale would combine the "training of trainers" concept with curriculum development and demonstration. For a selected number of top administrators, lay leaders, and professional staff in large long-term care institutions, a working conference could be organized to identify and specify appropriate elements of curriculum, methodology, and techniques (including instructional media), and to develop packages of curriculum materials for use in later training programs.

Such a conference should be held at a university setting, such as Syracuse, with requisite educational resources. It can be organized and conducted by an interdisciplinary team including mental health specialists, instructional media, and learning laboratory personnel, authorities on the aging and the aging process, and continuing education administrators. Trainees would be directly and actively involved in spelling out the elements of curriculum needed by those responsible for meeting the mental health needs of older persons in long-term care institutions—including the various types and sizes of such institutions and the kinds of "target" groups to be trained in each. The trainees would also be involved in defining the materials, instructional aids and techniques, and types of learning experiences for the organization of the curriculum. It is expected that the latter might include video tapes and simulation exercises dramatizing the attitudes, knowledge, and skills related to different levels of mental health service. The final outcome of this working conference would be the specification of a training "package" which could be applied in training programs organized by those attending this conference in their home areas. Such "back home" training would involve relevant institutional resources such as university departments, mental health departments, and other local expertise, in addition to the persons attending the working conference at Syracuse.

Following this conference, the university would organize a series of short-term workshops to demonstrate and test the effectiveness of the training package as applied to teams of personnel from long-term care facilities in Upstate New York. The teams would be composed of facility administrators, professional staff members, and lay board members from each institution. Resources for the conduct of these workshops at Syracuse University include specialists on the aging in the School of Social Work, personnel in the State's Psychiatric Hospital, the County Mental Health Department, the University's Instructional Development Center, departments of Psychology and Sociology at Syracuse University, and non-professional lay leaders of agencies who have had long experience relating community resources to the mental health needs of the aging. Evaluations of these workshops would be shared with the trainers who participated in the earlier working conference. The total effort would result in a refined training model to meet the needs of personnel responsible for mental health service in long-term care facilities.

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The Teachers College Program In Mental Health Training In Continuing Care Facilities

By Ruth Bennett, Ph.D.

TEACHERS College has taken a two-pronged approach to mental health training in continuing care facilities.

The first is the graduate degree program. The second is the planning of a Center for Gerontological Education and Research in collaboration with the Frederic D. Zeman Center for Instruction of the Jewish Home and Hospital for the Aged. The latter will provide an important continuing education capability to both the University and the Zeman Center. Together, the Teachers College and the Zeman Center will offer a continuum of educational opportunities for the Greater New York Metropolitan area.

An advanced graduate training program is offered at both the master's and the doctoral levels, focusing on the training of specialists in the field of aging. Areas of study include the psychology and the sociology of aging, retirement and health counseling, social services, program administration, and research methods.

Funded through a Title V Training Grant from the Administration on Aging, Social and Rehabilitation Services, Department of Health, Education and Welfare, the program had, during the spring semester, an enrollment of 80 full-time and part-time students. Of the 80, 44 are AoA Trainees: 30 at the master's and 14 at the doctor's level. Plans for the future include training more specialists at the doctor's level. Teachers College students of gerontology come from many disciplines, including social sciences, social work, psychology, recreation, nursing, nutrition, and health education.

At its inception in 1967, the program emphasized recreation and leisure education, considerable attention being given to the therapeutic function of recreation provided for the ill, disabled, or handicapped aging. This emphasis has not been continued. The program has been expanded to train gerontologists more broadly to work in all areas mentioned above.

Candidates prepare for careers in: (1) teaching and research in universities, and in national, international, local, public, and private agencies, institutes and institutions; (2) administration and direct service for specialized and multi-service agencies; and (3) consultation and planning to be of service to aging persons in recreation agencies.

Since Columbia University is located in a large metropolitan area, students have access to many agencies and institutions which offer rich research opportunities and field experience in aging. Research is carried on in collaboration with the Gerontology Staff, Biometrics Research of the New York State Department of Mental Hygiene.

At the beginning of the 1972-1973 academic year planning will begin for the development of a gerontological training center, the Center for Gerontological Education and Research, to be sponsored by and housed at Columbia University. It will have a cooperative relationship with the Frederic D. Zeman Center for Instruction of the Jewish Home and Hospital for the Aged, as well as with other agencies. The purpose of this Center will be to provide training in gerontology and services to the

aged at the paraprofessional, technical, professional service, professional education, and post-doctoral levels. In order to achieve its purpose the Center will concentrate on those research, service, and instructional activities which relate specifically to the conditions and problems of the aged residing both in institutions and in the community.

Students will be expected to bring to the Center, or to gain from other sources, the skills and competencies peculiar to their areas of specialization, such as recreation, counselling, health, and nutrition. Non-graduate training, as well as the clinical training of graduate students, will be the responsibility of the Zeman Center. Faculty from Teachers College will hold clinical appointments at Zeman Center and will supervise some clinical training.

An advisory committee will be established for the Center, consisting of persons representing the participating institutions, as well as the broader community, all of whom will be involved in one or another branch of gerontology.

The faculty of the Center will include representatives from such units as the School of Social Work, Graduate Faculties, the School of Business, the Law School, the College of Physicians and Surgeons, the School of Architecture, and the School of General Studies. It will be directed by a senior professor from Teachers College and by an associate director for non-graduate training from the staff of the Zeman Center. Advanced graduate students from Teachers College who are planning to be educators will train those at the paraprofessional and technical levels as part of their laboratory study. Students from other colleges and universities will be invited to utilize the resources for the Center for gerontological study.

Present and future plans for the Teachers College program in mental health are aimed at raising standards in the areas of training and obtaining and sharing mental health resources.

One assumption made by those teaching in the Teachers College training program is that work with the aged is as important as work with children. The ideal model proposed is that used for teacher-training. According to this ideal model (a) all staff in direct, daily contact with elderly people should have at least two years of college education which, if not obtained at a college, should be gotten through on-the-job training for college credit; (b) curricula should stress developmental psychology, biology, and other sciences dealing with the life cycle; (c) direct contact staff should be taught techniques of resocialization, remotivation, life-reviewing processes, and other behavioral techniques necessary to help the elderly in long-term care facilities improve their functioning and adjustment; and (d) staff should be routinely evaluated for their own job satisfaction and advancement, as well as for the benefit of the patients.

Many resources and facilities in the community, particularly in large urban areas, can be viewed as mental health resources, and there is no substitute for intelligence, creativity, and ingenuity in developing new ways of utilizing them. Students will be encouraged to spend time in internships in many agencies to learn how to use them for the benefit of the aged and to help sensitize their staff to the needs of the aged.

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A Multi-Service Geriatric Center As A Locus For Training

By Elaine M. Brody

THE importance of direct practical experience is conventional educational wisdom, expressed by such requirements as the internship of the physician and the clinical psychologist, the field placement of the social worker, the clinical experience of the nurse. Multi-service geriatric centers are often used as training sites to which students in various college and university educational programs are deployed for training of varying duration and depth. Thus, for example, the Philadelphia Geriatric Center (PGC) serves the educational community by receiving students from medical and nursing schools, graduate and undergraduate schools of social work, and from community colleges that train mental health workers. We also are host to residents in administration of long-term care facilities, and doctoral candidates in psychology, anthropology, sociology, and social work.

A Center therefore can provide as the learning laboratory the real world of older people, an opportunity to apply and test theoretical knowledge and skills "in vivo." The training situation is dynamic and realistic, since the auspice itself and training personnel are directly involved in providing care and services and developing programs. The populations served and therefore available for the student's learning experience include not only those who already are receiving long-term care, but groups of elderly who are "at risk" of institutionalization and their family members as well.

Students work in a context in which the collaborative interdisciplinary approach and an emphasis on mental health aspects of caring for the "whole man" are built-in. They receive direct supervision by skilled professionals and *participate in* (not simply *attend*) a multitude of staff meetings, conferences, in-service training programs and interdisciplinary staffings. The practicum is supplemented by a series of seminars, given by department heads and researchers, that cover content about medical, psychiatric, social, psychological aspects of aging, that emphasize the mental health aspects of care and review relevant research knowledge. The viewpoint is that understanding mental health aspects of care must be integrated into, not superimposed on training programs.

Formal, planned programs of in-service staff training are supplementary to the approaches that are an integral part of every procedure from the first contact of the agency with the older person requesting care and his family: careful counselling and exploration of alternatives, attention to psychological problems attendant upon application and admission, methods of facilitating admission in such a way as to support mental health functioning and so on.

Another dimension for students and staff is their exposure to research—to the processes of developing new knowledge and to the practical application of that knowledge in support of the mental health of the aging people with whom they are concerned. Of paramount importance to students in both practice and research is the demonstration of the interdependence of their skills; that is, the responsibility of the practitioner to help identify research issues and to participate in research, and that of the researcher to feed back relevant information. We agree that respect for rights of individual older people, respectful attitudes and tender loving care are vital. However, we also feel that "love is not enough," and that competence and skill based on knowledge are required. Our Mental-Impairment Research Project involved all levels of staff from outset and

its positive findings are now being systematically incorporated in treatment of residents.

We are suggesting that multi-service geriatric centers, with their concentrations of skilled practitioners and investigators, use their resources in yet another way. The training activities described so far are relatively traditional—that is, the formal educational institution providing theoretical knowledge and the geriatric center the practicum.

This conference has been called because of awareness of the pressing and unique training needs in long-term care auspices and because their different levels of personnel require training models that break with tradition. The knowledge and understanding of professionals and the programs offered by the facility converge at the point of service-delivery by practical nurse, aide, orderly, housekeeper, and maintenance worker. The most sophisticated plan of treatment and care depends for its practical implementation on these direct-care personnel who have little formal training and learn their jobs primarily through in-service training. A central issue in improving the quality of life for residents of long-term care facilities—and the phrase "quality of life" speaks to mental health needs—is that of devising effective methods to meet the training requirements of these non-professional workers.

Multi-service geriatric centers have the capacity, resources, and potential, and are uniquely suited to serve as trainers of direct-care personnel of other long-term facilities. Their administrators and other personnel, intimately familiar with the day-to-day tasks that must be carried out, with the nature of the population to be served and the population to be trained, with the aspects of institutionalization that may militate against mental health but can be changed, themselves involved with the same practical problems presented by residents and staff, are in a prime position to tune-in to other long-term care facilities, to establish rapport with all levels of their personnel.

Such staff are already related to potential organizational channels for application of training systems through membership in such organizations as professional associations, unions and educational institutions. To utilize such centers as the loci of training from which training programs reach out to other facilities in the larger community that do not have such concentrations of resources, would be an effective means of capitalizing on existing investments and maximizing existing resources.

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Johns Hopkins Pilot Program In Care For The Elderly

By Isabelle Carter

THE Johns Hopkins University has, in the past two years, piloted a unique program in the care of the elderly. Two new kinds of health personnel were trained to work in non-physician family health teams during a one-year educational period at the University: Family Health Advocates (FHA) and Family Health Team Supervisors (FHS) who direct the Advocates. The purpose of the training was to educate them to work with the elderly poor of minority groups, mostly black, in out-patient clinics as well as in homes in East Baltimore, administering medicine, advice, and comfort to the ambulatory aged who come to them.

In February, 1972, Johns Hopkins graduated the first group—12 Advocates, of which I was one, and five Supervisors. The Advocates function as "front line" workers, making the initial contact with the patients, either in the clinic or in the patients' homes. The Supervisors (four nurses and one medical corpsman) are responsible for diagnosing and treating most of the mild health problems seen and for recognizing problems which require referral to physicians and other health specialists.

In the future the Supervisor-Advocate team will be augmented with a third group who will receive health advocate training and complete an academic program. Dr. Archie S. Golden, coordinator for these training programs, visualizes this non-physician team as providing up to 80% of the necessary primary care needed by members of the East Baltimore Medical Plan as well as establishing health careers for men and women—high school graduates and non-graduates—from all socio-economic levels.

The training and work experience of the writer as a nurses' aide for many years and recently as a Family Health Advocate has afforded an opportunity to work very closely with a large number of elderly people on an individual basis. Through the close interpersonal relationships that have developed as a result of these contacts, it has become increasingly evident, there is a definite need for programs that generate activity and interest among senior citizens.

It is a well-known fact that a large number of elderly people are victims of depression or are confined to mental institutions simply because society has not developed techniques needed to offset inadequate usage of the brain. As effective as the Johns Hopkins program is in providing health services and counselling to the elderly, it does not yet have the capacity of encouraging a social and educational program. A suggestion is that the East Baltimore Medical Health Program, drawing from the Health Maintenance Organization (HMO) concept, should expand to consist of several curricula, including arts and crafts, sociology and psychology.

Once such a plan is instituted, the percentage of institutionalized elderly people would, hopefully, be considerably reduced while the institutions themselves could offer better individual care because of the decrease in their populations.

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A Multidimensional Continuing Education Model For A Mental Health Training Program For Personnel In Long-Term Care Facilities

By Albert G. Feldman, Ph.D.

COGNIZANT of the size of the elderly population in nursing facilities, of the importance of assuring that the long-term institutional nursing care be skilled, and of organizational theory and administrative behavior that can affect the quality of service delivery, the California State Department of Mental Hygiene and the Ethel Percy Andrus Gerontology Center of the University of Southern California joined forces in developing a multi-dimensional continuing education model for a mental health training program for personnel in long-term care facilities.

THE MODEL

In essence, the model developed—and now awaiting implementation and testing—is three-dimensional. The first dimension is one of organization and community organization, the second of coordination and cooperation, and the third of teaching strategies. There is a primary unifying goal, namely, to enable the patient, in nursing homes and extended care facilities offering skilled nursing care in Los Angeles to function at the optimal level of life satisfaction possible for him (retarding deterioration and/or facilitating some improvement in his functioning) by training nursing home personnel. Specifically, the project has undertaken to train 21 administrators and 21 directors of nursing from such facilities, the training centering around the understanding and application of mental health information by as many levels of personnel in the nursing homes as can be reached. And there are two correlative goals. The first is the development of a model for training that will have both continuity and a spread effect, the model to be tested with the nucleus of administrators and directors. The second is the development and testing of a feasible, effective, integrated enterprise that links the institution of higher learning and the mental health delivery systems and the long-term care facilities for the aged.

THE DIMENSION OF ORGANIZATION AND COMMUNITY ORGANIZATION

This is a necessary foundation for the model described here, and takes into account both internal (staffing and resources) elements of the sponsoring agencies and external, or community, factors that to a considerable degree govern the process and outcomes of the project. Thus, with regard to internal elements in the California State Department of Mental Hygiene is the matter of the Department's size-limited field staff in a public system with State hospitals for the mentally ill and retarded, that licenses and supervises private institutions for the mentally ill, and administers State programs of subvention of local community mental health services. And with respect to the internal elements in the Gerontology Center, cognizance must be taken of the fact that this multi-disciplinary facility for training and research in the field of aging has a major objective to translate current research and knowledge about aging into opportunities for application for utilization by those providing service, and the demands on staff and resources in this private institution serve also to circumscribe the scope of any single activity that

might be undertaken. Thoughtful deployment of staff and resources in both agencies is therefore mandated.

Yet this must be viewed as a positive situation. It necessitates careful advance examination of the scale of the task to be undertaken, the distribution and accessibility of the target groups (patients as well as facilities and their personnel), and the strategies that should be selected and employed in effectively and maximally involving the participation of the target groups. These assays into assessment, and developing involvement and participation, are proven community organization principles. For example, the California State Department of Mental Hygiene, a public system of state hospitals for the mentally ill and retarded, not only administers state programs of subvention in local community mental health services but licenses and supervises private institutions for the mentally ill as well. It is handicapped, however, by a size-limited staff.

Accordingly, meetings with representatives from various public and private organizations concerned with the quality of care provided in nursing homes were called by the State agency to ascertain, among other things, the degree to which they were willing to become involved in the project. The enthusiastic affirmative response led to correspondence with approximately 650 public and voluntary organizations, educational institutions, and nursing homes to test their interest in the project and their ability and willingness to contribute resources to it. One negative response was received against 250 positive replies. Advisory Committees were formed in each of four pilot regions outside the Los Angeles area, covering the larger part of the State, and initial planning meetings were held—already followed in two by training courses for direct care staff.

The Los Angeles region, with its enormous size, complexity, and diversity of populations and resources, required a different approach, but also one built on the careful community organization foundation constructed not only by the Department of Mental Hygiene but also by the Gerontology Center. An active and viable Advisory Committee on Continuing Education for Nurses had been created by the Center; a successful seminar had been conducted for nursing home administrators in response to needs expressed by participants in the various institutes and summer courses offered by the Center over a period of several years. From these sources and other pertinent groups an Advisory Committee was formed.

THE DIMENSION OF COORDINATION AND COOPERATION

This paralleled the organizational and community organization aspects of the continuing education/mental health model being constructed. How is an effective collaborative relationship to be achieved among a private institution of higher learning, a public state-wide mental health system, and institutional facilities supplying elderly persons with long-term skilled nursing care? The central variable, of course, comprises the two former—for institutional facilities for care of the elderly can move in and out of the picture, depending on a number of factors. But the key to this dimension lies in the common purpose perceived by the State agency and the educational institution, the readiness of the leadership in each to recognize and respect the contributions each has to make to the overall undertaking and to define and agree on the form, nature, and timing of the respective contributions. Such a relationship calls for a high degree of openness about the assets and limitations of each, and a mutual sharing of responsibility without either overstepping the established boundaries or abdicating to the other the performance of a disproportionate number of tasks.

THE DIMENSION OF TEACHING STRATEGIES

These, now in the process of development, will serve to achieve the project objectives to the extent that the other two dimensions are successful. At the same time, in many respects in can appear to be free-standing. To be sure, the focus of the training revolves around the understanding and application of mental health information by as many levels of personnel in the nursing home as can be reached. Ultimately, the nursing personnel providing the care to the patient will be the recipient of relevant knowledge about mental health and social gerontology. But the turnover in nursing manpower does not assure that the patient in facilities for the care of elderly will long benefit from the training to which the nurse was subjected—especially if the administrative atmosphere of the facility is not conducive to the direct application of the fruits of such training.

Consequently, a dual approach is being undertaken. One is a course of sessions with the administrators and directors of nursing to acquaint them with essential knowledge—emphasizing methods of training in mental health that *they* can adapt for use with their employees. This approach preserves the administrator's confidence in his perception of his role as the operator of his facility, with responsibility for communicating to his personnel his expectations about the quality of patient care to be proffered; it provides him with the satisfaction of being aware of the most current knowledge about needs, behavior, and treatment of his facility's elderly population; it is supportive to his administrative

control function; and—through his personal involvement and investment in the training—he responds to the expectations of his peers, the academic community and the licensing agency that he is *interested* in quality service and not just having beds filled. In essence, this approach is predicated on the necessary conviction of the two sponsoring agencies that the administrators *want* to enhance the knowledge and skill of their personnel in care-giving, that they have the *capacity* to do so, and that they will be given practical tools for doing so with current and future personnel as well as for creating the desired mental health climate for patient care.

The other approach is the implementation of what has been learned by the administrators and directors of nursing through regularly scheduled training sessions they conduct with their employees in the respective nursing home setting, where the administrators and nursing directors act as the trainers, with project staff present to supply consultation as well as guidance in teaching content and methodology. Hence the model's dual approach proposes simultaneously to equip the administrator and nursing director with mental health *information* and with *skill* in communicating this to employees for direct use in their own work with individual patients.

Three groups are being created of trainees from several facilities, each group to be brought together in one of three model facilities, which will serve as the facility site for the respective group's training. These facilities range in size from 172 to 337 beds, each with a range of patients, with from little or no psychiatric impairment to marked deterioration. The administrators and nursing directors selected as participants will be trained as a team, committed to applying the principles in their own nursing homes for at least sufficient (specified) time to permit reasonable opportunity for evaluation of effectiveness.

The course is being built around a modified systems approach to program planning, development, administration, and evaluation, with emphasis on meeting the psychological needs of the patient. It will be developed around three major areas: the didactic presentation (including team, collaborative teaching), clinical laboratory practice in the model facility, and application of the principles and concepts in the home facility. Instruction will include lectures, seminars, discussions, demonstrations, films and other audio visual aids. Guest instructors will be invited to present and discuss their particular arenas of expertise. Clinical laboratory practice in the site facility will enable the participants to select a group of patients to work with in the application of the theory being presented. Continuity of instruction will be insured by the Project Director's teaching role or by being present in all classes, and in his direct supervision of clinical practice.

Application of the principles and concepts in the participant's home facility will be initiated concurrently with his experience in the model facility. The Project Director will follow up the class and clinical laboratory practice with a weekly visit to each of the home facilities to assist in the transfer and consolidation of learning, and implementation of programs for patients in all the facilities.

THE EFFECTIVENESS OF THE MODEL

The process of evaluation of the effectiveness of this three-dimensional model will seek to answer several questions. The first is this: Did the content and format of the training model significantly alter the trainee's (administrators and nursing directors first, then patient nursing personnel) attitudes, level of sophistication and behavior deemed relevant to meeting patients' mental health needs? Another centers around the nature and extent of changes that might occur in relevant activities and programs in the facilities involved in the training program. And a third question to be considered is whether the project as conducted is in fact a viable model for a productive, collaborative, multi-organizational relationship (a private institution of higher learning, a State-wide public mental health organization, and nursing facilities serving elderly persons) in the conduct of programs of continuing education for mental health in long-term skilled institutional care for the elderly.

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Utilization Of A Proved Rehabilitation Training Team

By Barbara Finnie

THERE needs to be more than one way developed by which knowledge of mental health needs of the aging can be related to the practice skills and behavior of those who administer programs or provide long-term care services.

The geographic distribution of long-term care facilities in Illinois is as follows: 1/3 of the beds are in the metropolitan Chicago area, 1/3 in other urban areas of the State and 1/3 in rural areas of the state.

For the past twelve years Illinois has had a program known as the Rehabilitation Education Service (RES) Program working out of the Department of Public Health. These teams are made up of a Registered Nurse, a Physical Therapist and an Occupational Therapist. The team, at the request of the Licensed Nursing Home, goes into a facility for three weeks, full time, and trains the staff to use an activity and rehabilitation nursing program. Usually the Director of Nurses in the facility is required to have previously had a special three week rehabilitation nursing course at one of three hospitals in the state. The team then comes back to the facility periodically to check the program, give additional in-service training and otherwise motivate the staff to continue this special program.

Once the program is approved, additional money is paid for all welfare patients cared for in the home as recognition of superior service. The program has *not* become political in that no unearned approvals are given.

Homes in rural settings are faced with a complexity of problems that must be considered in developing educational programs. First, they are often located some distance from a major hospital where special skills might be available. Second, they are often located a considerable distance from a college or university where a continuing education program might be carried out. Third, there are often not enough interested persons to make a special localized adult education program economically feasible. Fourth, the educational level of the employees is often less than a high school diploma, and entrance requirements to some programs offered preclude them from participating.

The state of Illinois is preparing a program, similar to the previously explained RES program, to be known as the Social Rehabilitation Program. It is anticipated that an education service team or teams will be made available to train personnel *in* the facility as part of the implementation of the program. This allows training during regular working hours with those residents who will actually benefit. Patients/residents require a certain amount of education before a program will work. When employees and residents are trained together the program is much more effective.

Special education teams who do on the job training seem to achieve much greater results when compared to employees attending education sessions away from the facility. Then, too, there are those complicating factors, already commented on, which necessitate the development of special adult education programs in rural areas.

The proposed criteria for the Social Rehabilitation Program in Illinois are as follows:

The ultimate objective of a social rehabilitation program should be to assist the individual in becoming as self sufficient as possible within an environment that meets his needs. This may include learning or relearning those necessary social skills and/or vocational skills that will allow him to live in a less structured environment. To do this it becomes necessary that an individual patient's/resident's social rehabilitation potential be evaluated and that realistic, well defined goals geared toward specific behavior improvement be established for him.

These goals should be reviewed regularly and changed according to the needs of the individual. The facility's activity program and/or restorative nursing program should be developed. This is a voluntary program and not a requirement for licensure. It is a program that is evaluated by a three man interagency committee upon the request of the facility. If a facility chooses to develop this service then the following criteria must be met.

Prerequisite: The facility shall be currently licensed and providing an activity program in a sheltered care facility and a restorative nursing program in a skilled and intermediate care facility.

1. A professionally qualified person shall be required to supervise this program, or if the facility does not employ a professionally qualified person to supervise this program, such a person shall be utilized as a consultant, or a staff member of the facility who does not have responsibility for administering or directing nursing or personnel care shall be designated as having major responsibility as Social Rehabilitation Supervisor.
   a. This person shall have attained at least a high school diploma.
   b. This person shall have demonstrated leadership ability.
   c. This person shall be imaginative and creative.
2. If the size of the facility and the type of patients/residents admitted warrant, a professionally qualified person shall be required to supervise this program.
3. Additional personnel shall be provided as necessary to meet the needs of patients/residents and the program.
4. All personnel in this program should demonstrate the ability to relate to and work with people's social problems.
5. The Social Rehabilitation personnel shall participate in:
   a. Regular staff meetings.
   b. Inservice education, (orientation, skill training, and continuing education).
   c. Development of each individual patient's/resident's care plan.
   d. Training seminars on social rehabilitation and other related topics.
6. The Social Rehabilitation supervisor in addition to the above, shall:
   a. Identify individual patient/resident potential for social rehabilitation.
   b. Identify available resources in and out of the facility which may be utilized in an individual program.
   c. Coordinate a treatment program using this information.
   d. Evaluate the response and the results of the planned program.
   e. Further develop the individual program.
7. The Social Rehabilitation Program shall be reviewed and approved by the facility's Medical Advisory Committee or advisory physician.
8. Attending physicians will be consulted regarding individual patient/resident involvement in the Social Rehabilitation Program. Any limitation shall be stated in writing.
9. The activity program in a sheltered care facility and the restorative nursing program in an intermediate and skilled care Rehabilitation Program will be developed.
10. The Social Rehabilitation Program shall be designed for individual patients/residents and geared toward *specific* behavior improvement (social and vocational skills, attitudes and habits necessary to achieve acceptance in the community) as reflected in each individual care plan.
11. Each patient/resident shall be participating in those aspects of the program that meet his needs. The program shall include, but is not limited to, the following:
   a. The development of an individual's primary social skills:
      Social etiquette
      Literacy training
      Structuring of leisure time
      Basic money knowledge and management
      Independent community living
   b. Vocational (including homemaking and volunteer work):
      Evaluation of work potential.
      Training in specific jobs.
      Orientation to employment.
      Referral to and/or utilization of agencies.
      Job placement and/or on the job training.

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A Continuing Education Model In Mental Health

By Louise A. Frey

ANY continuing education program requires an educational philosophy, a statement of basic values and objectives and an approach to learning which are in harmony with one another and which provide the frame of reference of the program. Included in a frame of reference are educational theory, assumptions about how people learn and a structure for the development of educational designs which are based upon the characteristics and needs of the institutions in which they work.

Objectives for educational programs must be clearly stated and developed with those who are to be educated. The inclusion of learners in the initiation of an educational program through the identification of their own learning needs and through the sharing in the establishment of the educational design is vital to genuine participation. Without such inclusion people may attend educational programs, but not really join in the learning-teaching transaction. Educators who wish to capture the interest of learners must relate to the wish most people have to find new approaches which will make their job functioning easier, more satisfying and/or more efficient.

The first step in setting up a program for nursing home personnel is to discover who they are and what motivations they have for participating in a training program. Obviously the best way to know who people are is to meet them. Therefore, a first step for those who wish to conduct a training program is to set up exploratory meetings, not only with the administrators of nursing homes, but also with the workers. The task of determining with administrators and staff what it is that they need or want to learn is not accomplished by asking people what they want to learn, but rather by having them describe what they do and the problems they have in doing what they want to do, and what things go well and need no attention. In this process, the educator is able to help the group become interested in formulating an educational program based on felt needs. From the needs the major educational objectives are evolved, general content agreed upon, and an educational design suggested.

An important principle which is necessary in this process of involvement is the principle of parsimony of objectives. Delineation of the specific knowledge, attitudes, and the skills which are to be achieved puts the content into manageable units. (Tyler and Mager provide ideas about the method of setting educational objectives which can be very helpful in working with learners to develop a relevant curriculum.) Based upon the statement of objectives, the way the objectives are going to be achieved is worked out with the potential participants. For example, the nursing home administrators and their staffs may decide that one of the skills they want to learn is to help patients in their initial adjustment to the nursing home. As they explore this idea they would see that they need to understand the meaning of separation, the impact of group living, the sense of rejection, the meaning of depression, and so on. Their need would be for skills in helping the patient to talk about his reactions and fears, helping him orient himself to the physical as well as the social aspects of the nursing home and in bringing him into contact with other patients. They would need to understand and to accept the fact that anxiety, demandingness, and depression are natural, not pathological, characteristics of an aging person adjusting to a new situation. Also the worker would find it necessary to examine his frustrations at his own limitations in his attempt to deal with

the new patient's difficulties and to develop some understanding that, although his own negative feelings about aging are not unusual, they can get in the way of the patient's adjustment.

A learning design for getting at these content areas might be as follows. To achieve the attitude objectives, there might be delineation of typical new patient reactions and discussion of successful ways that the nursing home personnel have already assisted patients in making this adjustment. Such an approach would make it more comfortable to consider feelings and frustrations. Achievement of the skill of helping patients to adjust by talking with them could begin by some practice, through role play, in conducting an interview according to principles of interviewing presented by the teacher. Such didactic material can be useful to learners. However, if the learners are adults, the opportunity for expression of differing ideas and work on the incorporation and integration of new skills, knowledge and attitudes require that classes make major use of the discussion method. Experiential methods such as use of video tape, observations of interviews conducted by people skilled in interviewing, visits to other nursing homes, actual work with a small group under supervision, are also appropriate.

Every learning experience must be evaluated. Given our model of an adult learning-teaching transaction, the participants should be involved in the evaluation. The evaluation is based upon original learning objectives and includes an evaluation both by the learner himself of his own level of participation as well as of the course content and of the teaching method. An evaluation form which is based on the notion that learning takes place when people put what they have heard or discovered into practice is a most useful tool. Follow-up sessions and consultation serve both to evaluate and to consolidate learnings and support new practice.

The model being presented here is one which is based upon the articulated needs and wishes of the learners. The implementation of the model should result in a variety of educational programs suited to particular people, times and places. It starts where people are, and moves and grows with them. It is not a packaged program, yet it is full of content.

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Two-Level Training In Mental Health For Personnel In Long-Term Care Facilities

By Hiram J. Friedsam, Ph.D., Robert H. Dovenmuehle, M.D., and Herbert Shore, Ed.D.

A program for continuing education in mental health for personnel of long-term care facilities should be directed to: (1) administrative staff of long-term care facilities, and (2) low-skilled personnel who are in continuous day-to-day contact with residents. In addition to the obvious objective of improving mental health knowledge and competence, the objectives of training at the administrative level must also include securing the administrator's cooperation in reaching low-skilled personnel who are trained (by institutional change, if necessary), and developing an interest and concern for in-service training in mental health. Given the high rate of turnover of nursing home personnel, only the latter can insure long-run results. For low-skilled personnel the objective is increased awareness of and skills in the use of mental health content appropriate to educational backgrounds and positions.

Training, therefore, appears to involve a two-phase or two-level process. In the first phase training should be directed to administrative staff to be followed by training directed to the low-skilled personnel. Training should occur in the community, but not necessarily in the nursing home. However, a consultant relationship between the training organization and participating homes as a means of follow-up would be highly desirable. It is suggested that training organizations develop working relationships with community mental health centers in the conduct of training and in the development of the consultation capability.

There is sufficient content available for training programs, although it will have to be adapted to the needs and educational backgrounds of the trainee populations. Content should include the following: understanding the aging process, including illness and death; the behavioral and adaptive mechanisms of the elderly person; the various treatment modalities; the

social components of care; the mental health role of activity and other programs; community resources, including training resources.

Evaluation should be directed towards assessing changes in attitude and in job performance of those exposed to training. However, the changes in "climate" of long-term care facilities whose personnel receive training is the ultimate test of the effectiveness of training activities. Therefore, evaluation should also undertake to assess institutional change.

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Education In Mental Health For Personnel In Long-Term Care Facilities

By Eddie W. Gibbs

THIS statement will not speak to the technical requirements of a continuing education program for personnel of long-term care facilities but, rather, will address the nature of the present problem of providing quality service as it relates to mental health needs of the patients/residents.

Homes for the aged and nursing homes have important contributions to make, both quantitatively and qualitatively, in the delivery of health care. Some advocates for increased long-term institutional services suggest that the nursing home ought to be able to meet all of the mental health needs of the patient/resident. Others would insist that the status quo be maintained and that the long-term care facility has no role to play in assisting the individual, insofar as his mental health needs are concerned.

Between these two extremes lies an intermediate position. In some areas of service—mental health is one—the nursing home or home for the aging more often than not must depend heavily on other community agencies and services. The long-term care facility must not become a scapegoat because of society's failure to provide adequate facilities and services elsewhere.

A successful program of continuing education for personnel in long-term care facilities around the mental health component of care is not possible unless it can be demonstrated that the final concern is with the total human being as determined by his physical or medical needs and especially as molded by his individual and unique social experience.

Today, almost out of necessity, too many administrators and other personnel in long-term facilities are more responsive to a distant authority or regulatory agency than to the total needs of the patient/resident. Compounding the problem is the frequently held view and complaint often made by long-term care personnel that there is little they can do to contribute to good mental health of the patient/resident. Such a position represents both a defense against the necessity of doing more and the image often given to the long-term care facility.

Every long-term care facility has its "problem cases" and the personnel are often overwhelmed by the behavior of these patients. In situations of constant stress, the usual professional courtesy and typical safeguards provided to the patient/resident tend to break down and personnel frequently become curt, even punitive, in their attitudes and behavior.

Personnel in long-term care facilities must come to see atypical behavior of the patient/resident as dependent upon explanations which ultimately are not divorced from "normal" behavior. What many personnel cannot see at present is the similarity between normal, everyday behavior and the behavior of the patient/resident they consider incomprehensive. These personnel cannot see the relationship between environmental factors within the long-term care facility and patient/resident behavior. The importance of satisfying human needs and assisting the individual in feeling adequate rather than deprecating him must be emphasized to all personnel, administrators included. Continuing education must help personnel dispense with a concept of blame and supplant it with that of understanding.

An aim must be to transform institutional practices rather than merely to expand them. A continuing education program must be based on the conviction that not only quantity but the quality of service as a whole must improve and that only a commitment to new principles of operation can produce an overall qualitative change in practice.

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An Educational Model In Continuing Education For Mental Health In Long-Term Skilled Care For The Elderly

By Elaine Goldman

THIS is a proposed collaborative educational model between mental health, continuing education and nursing home personnel to help personnel provide innovative care of the aging in long-term care institutions. Sponsored jointly by the Schools of Social Work and Nursing of Adelphi University, this model will increase understanding and cooperation between nursing home administrators, supervisors, and care-givers, both professionals and paraprofessionals, within a given agency and/or between agencies. From various Long Island institutions, teams of trainees will have an opportunity to increase their knowledge, skills and resources in order to create a structure and a climate conducive to improving the mental health status of nursing home residents.

AN AGED PERSON AND HIS EXPERIENCE

One view of the problems associated with aging is at the level of the individual person. The aged person experiences feelings of helplessness, inadequacy, and impotence. He frequently converts these feelings into controlling, manipulative and exploitative behaviors. Training is needed by caretakers to prevent and/or intervene in these and other well-known defensive patterns so that persons residing in long-term care facilities can be supported toward the maintenance and retention of healthy levels of functioning. In terms of the mentally impaired patient, practitioners need to assume the role of patient advocate on behalf of his needs and rights as a human being. However, for the mentally alert and/or ambulatory resident, needs go beyond physical security and include self-realization, personal growth and involvement in his future—i.e., planning and decision-making to meet his needs.

Effective decision-making is related to the availability of appropriate social solutions and the ability to put them into practice. Therefore, professionals, paraprofessionals, and volunteers need to (1) become more responsive to the aged and how they experience their own problems and (2) become more knowledgeable of available agency and community resources. The usual caretakers and decision-makers at all levels need to become aware of their own attitudes and behavior toward residents and their families. They need to explore how inadvertently, due to lack of knowledge about the aging process and/or failure to apply knowledge, they have increased the patient's dependency, psycho-social decline and physical impairment.

OBJECTIVES

The proposed program is designed to correct some of these deficiencies. The specific objectives are to help participants:

1. Increase their knowledge of the psycho-social-physiological process in aging.

Understand:

a) how the aged experience themselves and their problems;
b) the way one sends and/or responds to messages;
c) different life styles and value systems;
d) how feelings influence behavior.

2. Increase interpersonal competence enabling them to establish and maintain meaningful contact with residents and staff.

   Develop skill in:

   a) listening;
   b) sharing emotional reactions to planned or spontaneous behavior;
   c) practicing communicating one's feelings and ideas in helpful ways.

3. Increase ability to assess physiological, psychological, and sociological needs.
4. Become skilled in detecting and preventing maladaptive patterns of the institutionalized aged.
5. Develop an awareness of the special needs of the mentally impaired aged in institutions and to provide skilled intervention to maintain optimal functioning.
6. Increase their knowledge and utilization of available internal and external resources.
7. Develop group leadership skills:
   a) group process and group dynamics;
   b) techniques for group leaders.

TRAINEES

The training program relates directly to all personnel regardless of their discipline, role and function. Trainees will be recruited in teams of at least three from each nursing home. Teams from different facilities will vary in their professional compositions, but the total group will include administrators, nursing supervisors and in-service educators, social workers and/or social work aides, occupational, physical, and recreational therapists and their corresponding aides, head and staff nurses, registered and practical nurses and nurse aides.

In addition to the acquisition of relevant knowledge and skills necessary to provide competent care of their clients on an individual basis, opportunity will be provided for personal growth. To generate new and creative ways of intervening therapeutically in the traditional structure and climate of long-term institutions, all personnel need to be committed to education as a continuing process. Common goals regarding human services and planning for implementation are necessary in order to have an impact on the system.

TRAINING PERSONNEL

All courses will be taught by faculty recruited from Mental Health agencies, Continuing Education programs of the Schools of Nursing and Social Work, and Nursing Home facilities. All courses are experientially based and will be carried out predominantly in small group work, with mixed interdisciplinary trainee groups in each small group.

TRAINING PROGRAM

The program consists of three sequential courses:

MENTAL HEALTH AND GERONTOLOGICAL PRACTICE IN NURSING HOMES

Eight sessions–One day a week,
8:30 p.m.–3:30 p.m.

This course offers the trainee an opportunity to grasp the relationship between sociological, psychological and physiological phenomena of aging. Emphasis is on maintaining optimal functioning through a guided theoretical and practical assessment of and intervention into the psycho-social, physiological, and environmental aspects of aging in institutions, including effective utilization of internal and external resources. Structured exercises will be utilized to (1) foster authentic relationships between all levels of trainees and (2) promote clinical and interpersonal competence.

GROUP PROCESS AND GROUP DYNAMICS

Eight sessions–One-half day a week,
12:30 p.m.–3:30 p.m.

This experiential group course is designed to increase the trainee's effectiveness both as a group member and as a group leader. Learning is achieved through the examination of the actual experience of the group. Trainees will have an opportunity to (1) increase their awareness of their reactions to and impact on others, (2) become acquainted with processes common to all kinds of groups, (3) become more effective in expressing what is going on with them, (4) experience those forces which influence group behavior, and (5) practice intervention.

TRAINING GROUP LEADERS

Eight sessions–One-half day a week,
12:30 p.m.–3:30 p.m.

This is a continuation of "Group Process and Group Dynamics." Trainees who are not currently leading a group will need to select a group to work with on a weekly basis. Groups may be comprised of residents,

family, staff, or community groups related to the institution. The purpose of the group may be decided by the group course. There will be discussion of trainee's group work as well as an examination of the actual experience of the group.

FOLLOW-UP TECHNICAL ASSISTANCE

Teams trained in the program will receive from one to two days of on-site follow-up technical assistance from one of the faculty who worked with them in the program or from a consultant, depending upon what is needed. Follow-up takes place when courses are completed.

TRAINING METHODS AND RATIONALE

The training includes lectures, discussion, and structured experiences. The structured experiences grow out of a theoretical framework which guides the practitioner in initiating and maintaining meaningful contact with residents, family members, staff, and the community. It is essential for practitioners to learn how the aged person experiences himself and his problems in order to help him deal with what he perceives, how he interprets his perception, and the way in which he responds.

The emphasis is on experiential learning. The rationale for this choice is that participants are frequently unable to make meaningful contact and deliver needed services to the aged because of their own negative attitudes, misconceptions and misinformation. Participants frequently believe they are able and competent to deal with the aged, but their behavior demonstrates their real difficulties.

Group experiences help personnel to deal with interpersonal and group living problems with depressed, regressed, confused patients and their families. In addition, these experiences are helpful in exploring and resolving intergroup conflict caused by the racial and ethnic composition of staff and of patients.

EVALUATIONS

There will be a continuous monitoring of the program's operations by the trainees. This allows participants to review the work in progress in relation to the stated goals and their own needs. Based on these reviews, appropriate modification in the program will be made.

A major objective is to effect some change in the trainee's behavior in his job performance. Trainees who have attended all three courses in the program may be expected to:

1. Mobilize people in the interpersonal network and agency network in a cooperative effort to deal with patient problems, either individually or in a group;
2. Prevent duplication of services in the agency or community;
3. Participate with other professionals and paraprofessionals in the decision-making process concerning patient care;
4. Become introspective: (a) describe or express in personal terms one's own feelings, (b) be sensitive to and value the communication of feelings;
5. Assess, i.e., describe and predict the factors affecting (a) the resident, (b) the unit, and (c) the agency through interaction with these three systems;
6. Assess the effect of the resident, unit and agency on one's self;
7. Plan action on the basis of the assessment;
8. Implement action, i.e., produce constructive change.

These outcomes need to be further defined operationally so that performance measures may be obtained.

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Integrating The Care Of The Nursing Home Patient: A Proposal

By Leonard E. Gottesman, Ph.D.; Teresa C. Fada, R.N. and Irene Garrett

GOALS to be sought in the effective care of the nursing home patient may be summed up in one encompassing word: *awareness*—awareness of ways to prevent mental breakdown in the aged; of the needs of the aged ill should functional or organic breakdown occur; of the necessity of integrating mental health care with psychosocial, restorative, and personal care; of the use of community resources and alternatives, and the function of team work in fostering programs.

In working toward these goals, administrators and staff of nursing homes must solve numerous problems. First among them are those concerning the residents themselves, many of whom are likely to be marginal people. Many never married or contracted unsatisfactory marriages. For others, crises have occurred in previously successful relationships. They are in the homes as a last resort for themselves and their families. Their futures seem to hold for them only separation, emptiness, illness, and death. As a consequence, their social relations are disturbed.

In general, the homes themselves are set up to give custodial care (at best some restoration) but not psychosocial care. The focus is on maintenance or the treatment of the ills of the patients, but not on establishing a milieu for living. They are cut off from the community that surrounds them but often resents their presence.

The staffs are meager, rigidly hierarchical, and have few specialists. Most patient contact is by the lowest level staff. These operational staff are usually young, inexperienced, poorly paid women who are the main support of their families. Our current study in Detroit revealed that take-home pay for aides averages between $50 and $60 a week; time off is minimal and irregular, and many reported that they are often called and persuaded to work on their days off. Despite these strains we found 56% of nurses' aides to have been in their current job one year or more and most of them were committed to giving good patient care.

The licensed practical nurses and registered nurses, though better educated, better paid, with longer tenure, share an interest in good patient care but because of their supervisory responsibilities often have adverse relations with operational staff. Very often the conflicts which the administrator and Director of Nursing have with the government in their struggle for licensure and financial support divert their attention from the immediate needs of the home and its residents. These tensions lead to conflicts in the minds of other employees about their appropriate roles and are disturbing to the residents.

Two assertions which all levels of nursing home staff accept are that virtually every resident and staff member is operating below the level where he or she could operate and that desirable goals are to make the nursing home a "pleasant place to live" and to stimulate better relationships among residents and between residents and staff. They agree that reaching these goals would make the nursing home a better place to work. Improvements in these two consentually accepted shortcomings are therefore the object of the training program.

To honor the hierarchical organization of the nursing

A Sample Course Unit

Need Relationship:

A. Need - What: relationship, communication

Why: expression, security, recognition affection, belonging, dignity

B. Common solutions: Who: family, friends, associates, God

How: interaction, looks, touch, phone, write, prayer, alternate life styles

C. Problems: Loss of others, loss of ability, loss of supports, CBS, aphasia, biological changes

D. Solutions: Pt. - interaction with pts., staff, family; visits out, day hospital, church

Envir. - furniture groups, rooms arrangement, content in life

Staff - provide physical and social environment, be friendly, accept individual differences, encourage relationships, allow independence, relate to dying person

E. Resources: Location, activity groups, remotivation techniques, church, social action, pub

F. Roles of team members

1. General case
2. Specific home

home the training program approaches each staff level separately. The in-service program for supervisors is designed to (1) get their acceptance of the proposed goals for the facility; (2) to teach them principles of supervision and staff relationship; (3) to help them gain the confidence and support of the operational staff; (4) to encouarge them to utilize the conference method of operating the organization; and (5) to educate them to the value of engaging expert teachers from other homes, government agencies, and universities to stimulate with fresh ideas and open discussions.

The heart of the program should revolve around the operational staff (aides, housekeepers, food service people) to help them understand and accept mental health psychosocial goals in the care of the patients, who are usually elderly, and to teach them to work in teams and to utilize community resources. What is essential is to show them how to build a "way of life" for residents by integrating restorative and personal care with psychosocial relationships.

The training program for operational level staff would use small group sessions, led by especially trained indigenous operational persons selected because of their demonstrated leadership.

Learning would take place through role playing and participation in a "nursing home simulation" in which the students would play nurse, patient, administrator, etc. and deal with such representative focal issues as "incontinence," "acting out," "new admission," "apathy and withdrawal," with the planning and execution of the total home's day, week or longer period and with designing programs to meet patient needs.

We have already developed and used aspects of this training program in our Ypsilanti State Hospital milieu treatment project and more recently at the Philadelphia Geriatric Center. While a full test of the program is yet to be made, our efforts seem to have paid off in increased job satisfaction, better attendance, and actual upgrading of staff function.

An outline of one class unit on the need for relationships is presented in the table above. First the need is described, then typical solutions used by people outside of institutions, problems which

impair meeting of needs, a variety of new solutions and resources and some of the possible staff roles.

Because the approach to learning is novel, it should be evaluated for both the success of class sessions and the effects of training on staff performance. Some possible measures of the latter being (1) job attendance, (2) expressed attitudes, (3) employee, employer and patient satisfaction, (4) observed staff behavior and (5) staff evaluation of the program's effectiveness.

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Notes On Continuing Education For Nursing Personnel

By Laurie M. Gunter, R.N., Ph.D.

IN an effort to promote mental health for both residents and personnel in long-term care facilities, consideration should be given to the total milieu. Policies governing the recruitment, selection, training, and promotion of personnel directly influence the amount of humanistic concern and care which can be expressed for the residents. Policies which exploit workers through the employment of personnel who themselves have great difficulty in coping with the stresses of life and paying them the lowest possible wages because they are unskilled, place the residents in a situation wherein they too are likely to be exploited through the disinterest of the workers in their welfare. Thus the basic assumption of this proposal is that continuing education should upgrade the knowledge and preparation of the personnel who work directly with the residents of the long-term care facility and be reflected in increased salary, job satisfaction, and opportunity for job mobility.

A Committee of the Division on Geriatric Nursing Practice of the American Nurses' Association, composed of Myrtle I. Brown, Marie D. Grant, Lois I. Knowles, Harriet C. Lane and Dorothy V. Moses, has prepared a set of "Standards For Nursing Practice," which may be used as a basis for continuing education programs as well as a means of evaluating performance of nursing personnel. The June 1972 issue of *Nursing Clinics of North America* includes an article elaborating on each of these standards, which are as follows:

- ...*The nurse demonstrates an appreciation of the heritage, values, and wisdom of older persons;*
- ...*The nurse seeks to resolve her conflicting attitudes regarding aging, death and dependency so that she can assist older persons, and their relatives, to maintain life with dignity and comfort until death occurs;*
- ...*The nurse observes and interprets minimal as well as gross signs and symptoms associated with both normal aging and pathologic changes and institutes appropriate nursing measures;*
- ...*The nurse differentiates between pathologic social behavior and the usual life style of each aged individual;*
- ...*The nurse supports and promotes normal physiologic functioning of the older person;*
- ...*The nurse protects aged persons from injury, infection, and excessive stress and supports them through the multiplicity of stressful experiences to which they are subjected;*
- ...*The nurse employs a variety of methods to promote effective communication and social interaction of aged persons with individuals, family, and other groups;*
- ...*The nurse, together with the older person, designs, changes, or adapts the physical psychosocial environment to meet the needs of the latter within the limitations imposed by the situation;*
- ...*The nurse assists persons to obtain and utilize devices which help them attain a higher level of function and ensures that these devices are kept in good working order by the appropriate persons or agencies.*

Another basic assumption made with regard to mental health in long-term skilled institutional care for the elderly is that mental health cannot be separated

from physical care and well-being. For this reason, a general outline of course content in geriatric nursing is suggested. This should include the following:

1. Basic personal care (physical and mental)
2. Restorative nursing
3. Health maintenance
4. Utilization of resources
5. Basic concepts of aging process
6. Societal problems associated with aging
7. Medications
8. Governmental functions and agencies, including Medicare

Specific content should be included to provide nursing personnel the knowledge of psychopathology in adult life with discussions of the crucial problems of the aged. Personnel need considerable preparation directed toward mental disease in old age with the aim of developing methods and skills for working with residents suffering from acute and chronic brain disorders, functional psychoses, neuroses, and psychosomatic disorders, and other abnormal behaviors.

In addition to the traditional continuing education courses designed usually for the professional level nursing personnel who, in turn, use their preparation in the design of in-service education programs for non-professional personnel, it is proposed that some community-service programs may be offered through continuing education. These community-service programs might include consultation and research for a specific long-term care facility. In this way, consultants and faculty could work directly with nursing, dietary, and housekeeping personnel having direct contact with residents. Results of research could be used as feed-back and for discussion and learning purposes to improve the milieu and care practices.

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A Pilot Nursing Home Education Program In Massachusetts

By Bennett Gurian, M.Sc., M.D.;
Anne O. Freed, M.S.S., and
Louise Frey, M.S.W.

THIS past year the Massachusetts Mental Health Center in conjunction with Boston University School of Social Work, Division of Continuing Education, conducted a Pilot Nursing Home Education Program now being expanded on the basis of information gathered from the pilot experience.

The faculty, representing the fields of psychiatric nursing, internal medicine, psychiatry, psychiatric social work, dietetics, and nursing home administration, were drawn from the Massachusetts Mental Health Center, Peter Bent Brigham Hospital, Brookline Mental Health Center and several nursing homes. Prior to the Program, they had attended a seven-session seminar with leadership provided by the Boston University School of Social Work, Division of Continuing Education, in which goals were evolved, teaching methods discussed, adult education theory emphasized, and a curriculum prepared.

The Program itself, consisting of six seminars each in four geographic neighborhoods with teams of four faculty members, was attended by 157 nursing home personnel, representing 35 nursing homes and two corporations, primarily in the Catchment area.

The educational model which emerged from the Pilot Nursing Home Education Program is based on several important philosophical premises:

- *. . . that continuing education for adults and for various professional groups must involve the learners from the beginning in an active contractual relationship, with learners participating in identifying their educational needs;*
- *. . . that the teachers or trainers need to have a clear understanding and knowledge of adult education methods and theory;*
- *. . . that teaching in the field of mental health includes not merely imparting information and contributing toward new skills, but also involves attitudes towards patients and programs that implement these attitudes;*
- *. . . that if the educational process is to succeed at all it will involve the learner as a change agent;*
- *. . . that an effectual educational program must have built into it chain teaching—i.e., learners become teachers and the ripple effect takes place as learning is communicated from one person or one group to another;*
- *. . . that an evaluation process needs to be built into an educational program of this nature if its effectiveness is to be properly assessed and if it is to have further implementation and adaptation.*

The next phase of this program involves the

appointment of two mental health educators with social work and some teaching background, one to be located in the Massachusetts Mental Health Center and the other at Boston University School of Social Work, Division of Continuing Education. Each will be given a joint appointment. They will establish, administer, and teach a series of workshops, seminars, and institutes for nursing home personnel. The curriculum will be determined after extensive consultation with the nursing homes in this area. They will, in addition, upon the inception of the Program, establish a trainers' seminar as a follow-up on the recent Pilot Program in which many nursing homes indicated interest in setting up their own in-service mental health programs utilizing leaders who had attended the Pilot Program. They will act as consultants to these in-service programs as they get under way. Thus, the implementation of educational programs and its spread will be built-in and supported. For those homes not participating in the Pilot Program and those homes wishing to train new personnel in mental health principles at least two seminars replicating the Pilot Program will be established. This will necessitate working closely with the homes to help them recognize and acknowledge the relevance of mental health content to their work.

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Essentials Of Continuing Education For Practitioners In Long-Term Care Facilities

By Sandra Hall, R.N., M.S.

KURT Lewin has equated adult education with cultural change. A dramatic illustration of this equation is the education of large numbers of persons to skillfully and humanely care for the aged and chronically ill.

In California, long-term facilities care for the mentally ill, chronically ill and mentally retarded of all ages. These institutions struggle with ever-changing and conflicting governmental regulations. A question yet to be clearly determined is who has the primary responsibility for patients in these facilities. In actual practice, registered nurses, working with licensed vocational nurses and unlicensed aides, have the major responsibility for care of most of these patients.

Some content value areas considered by this writer to be essential parts of continuing education for all practitioners caring for the aged and chronically ill are:

1. Including the physiological aspect of care in psycho-social discussions;
2. Stressing humaneness, particularly with regard to the patient's wishes to participate in decision-making about himself;
3. Encouraging innovativeness in personnel's approach to situations. For example, the social worker-nurse consultant team who conducted therapeutic community meetings in a nursing home discovered the meetings were more effective when preceded by a patient-staff cocktail hour;
4. Expanding the knowledge, responsibility and role of the registered nurse—University of California at San Francisco and Franklin Hospital Extended Care Facility have designed a Master's degree program in Nursing, beginning Fall, 1972, to do this. The curriculum includes gerontological and nursing content, supervised clinical practice, and an internship. Expanding and legitimizing nursing responsibility might result in a role-change for everyone;
5. Providing continuing education programs for all levels of nursing personnel now practicing together in nursing homes to include: a) content based on gerontological knowledge and research findings; b) clinical components based on the application of knowledge in actual care setting; c) resource people who can be role models; d) planning and decision making skills and practice; e) promoting the effective use of multi-disciplinary consultation; and f) cross-fertilization of ideas between agencies; a prerequisite to multi-disciplinary training;
6. Including administrators of nursing homes and related facilities in planning and implementing the training of personnel;
7. Providing multi-disciplinary continuing education for professional practitioners of diverse consultative capacities to increase their skills in consultation, teaching and collaborative planning with nursing staff.

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Citizens' Education As A Prelude To Continuing Education Of Institutional Personnel

By Sandra C. Howell, M.P.H., Ph.D.

THIS brief statement addresses itself to the issue of long-term care settings in terms of their impact as residential environments on the mental health of resident and staff and on the neighboring communities.

Because long-term care facilities have, historically, been modeled after the hospital as an institution, they do not readily bend in the direction of extension of life experiences which elderly residents desperately require. The use of space within nursing home environments has tended to reinforce, for both residents and staff, the image of the living environment as a "treatment" center. As a consequence of the "treatment" atmosphere, the potential for behavioral change, particularly for the mild to moderately impaired elderly, is severely constrained.

It is now known that environmental modification can profoundly affect human behavior. This knowledge has inadequately been translated and put to use within long-term care settings.

Prerequisite to developing continuing education programs in mental health, there is a need to address the problem of environmental quality. Nursing home administrators can only develop clear and continuing awareness of the environments they provide and, in turn, become willing to radically modify the on-site community, spatially and socially, when they begin to relate in terms of their residential manager function as much as their institutional director role.

It must be recognized that there is an inherent contradiction between licensure requirements for the nursing home as a medical care facility and the conception of the nursing home as a residential environment. Thus, in order to emphasize the health service skills which an aide needs to support the treatment goals of the professional staff, it has appeared necessary to negate the more informal and natural behaviors which could contribute to the development of flexible, homelike settings.

Firmly scheduled activities for residents and staff are rationalized as efficient operation. If our goal is to upgrade the quality of life in nursing homes, it may be necessary to systematically reduce, via ongoing in-service training, the professional aura of the environment.

Health professionals cannot initiate, design and direct training for nursing home personnel related to deinstitutionalizing the environment without a heavy infusion of behavioral science in the continuing education program. Their investment in maintaining the roles for which they were very formally educated is too great.

An alternative strategy would be the development of local nursing home advisory councils composed of community elderly. Building continuing education into nursing home environments involves opening both residents and staffs to intrusion from the natural neighborhood, i.e., breaking down the insular qualities of such settings.

Experience with several types of elderly citizens' advisory groups indicates that such groups are quite capable of matching their sensitivity to environmental barriers to good mental health with inputs of specific knowledge of alternative structural, design or staff behavior solutions.

Examples of the potential of community elderly as change agents in residential environments in Massachusetts:

a. The Massachusetts Legislative Council of Older Americans has developed teams of nursing home visitors whose limited goals have thus far been concerned with enlarging the opportunities for residents to reenter the community via both formal and informal participation in off-site activities. They have the people, but they need the financial and professional support to expand their skills and to evaluate their impact;

b. Massachusetts Councils on Aging are, in several communities, actively engaged in environmental and residential site planning with the professionals in architecture, health services and public administration. They have learned how to read blueprints and what questions about social and private space may be of relevance to people their age;

c. Elderly residents of Boston Public Housing now sit on the tenants' council which is currently suing the Housing Authority for a lack of follow-up responsibility for residential maintenance and program development;

d. Elderly church affiliated groups, forcibly relocated from Boston's West End, are threatening suit against the city and state for non-replacement of housing in their familiar parish neighborhood.

All of these examples suggest a basic level of awareness of how the living environment affects mental health. It is suggested that continuing education for personnel *in* long-term care facilities build on the strengthened awareness of community aged whose influence over policy and practices within institutions and residences can truly be persistent.

CONTINUOUS EVALUATION OF THE RESIDENTIAL ENVIRONMENT

It is possible to design an environmental evaluation instrument to measure the quality of life in a long-term care facility that can be administered first by non-institutional community elderly, by families and by non-professional staffs. The health professional needs this check and balance to control over-emphasis on the "treatment environment" and to develop transitional environments to prepare patients for return to a real community setting.

Following are a few of the considerations which such an evaluation should include:

1. Sensitivity to the physical characteristics of the facility which allow for resident autonomy and freedom of expression.
   a. spaces for privacy and the retention of personal property;
   b. spaces for movement with and without constant supervision and free of unnecessary barriers;
   c. access to settings customary in daily living functions;
   d. stimulation from physical and spatial variety inside and outside the structure;
   e. inclusion of familiar cues from the non-institutional living environment.
2. Sensitivity to the performance of staff in utilizing the spatial and physical qualities of the environment.
   a. regulations or behaviors which unnecessarily prevent residents from manipulating territories and time;
   b. lack of responsiveness of staff to the needs of residents for resocialization in an alien environment;
   c. creation of artificial barriers to privacy or mobility;
   d. provision by staff of opportunities for residents to engage in experiences which would support intermittent independence or positive changes in health status;
   e. existence or absence of programs, procedures or spaces which would provide opportunities for possible re-entry into the non-institutional community.

Admittedly, it is very difficult to focus upon these environmental behavior issues when so many long-term care facilities operate at a relatively low level of medical and technical skill. However, it might be wise to pose the question to the elderly as to whether they would rather reside in a home-like atmosphere in or near their own neighborhood or a nursing care atmosphere near a large medical center. The job of the educator is to optimize both aspects of long-term care settings.

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An Administrator's View Of Long-Term Care For The Elderly

By Sister Phyllis Hunhoff

IN the growth of numerous new nursing homes across the country, structural requirements, physical safety standards and 24-hour nursing coverage have been the main areas of emphasis. It is time, now, to emphasize the philosophy and program content within these structures.

What do we see as an ideal situation for our elderly within our facilities? It would seem to include the following:

- . . . *therapeutic, restorative care enabling the elderly to return to the community following a major illness;*
- . . . *a professional understanding of and approach by personnel to the total needs of the elderly;*
- . . . *comprehensive knowledge of the available community resources to assist the older person in making decisions for his/her future;*
- . . . *long-term care (for those with permanent major disabilities) which provides a total living situation;*
- . . . *studies to help understand difficult areas in the care of the individual with behavioral and senile problems;*
- . . . *admission procedures which evaluate the need for institutionalization with options for other arrangements;*
- . . . *financial recognition (cost/day) of progressive programs.*

This ideal, of course, must be striven for. As knowledge in the field widens, the administrator must be constantly alert to developments in management techniques and scientific advances and see to it that every member of the facility he supervises is continually trained and re-trained in the components of long-term care.

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Improving The Training Of Health Paraprofessionals

By Jacquelyne J. Jackson, Ph.D.

CRITICAL to developing an educational model for mental health training for long-term care facilities is the recognition that variations among such facilities within and between the major National Institute of Mental Health subdivisions within the United States make it necessary to develop several different models. In doing so, such factors as the different levels of personnel and the heterogeneity of their prior training, competence, and interests, the demographic variability characteristic of personnel and patients, and the varying modalities of treatment or care employed at institutions must all be considered.

This brief paper concentrates specifically upon one group: nursing, housekeeping, and food service paraprofessionals employed or likely to be employed in the South, the vast majority of whom are or are likely to be black females. Many of these black females are family heads or, if in husband-wife families, significant contributors to their total family income. Most often, they labor diligently for wages at or below the poverty level without even receiving minimally desirable fringe benefits, such as those of an established period of two consecutive days away from and five days at work during each week.

Much of the delivery of daily direct services in nursing home or long-term care facilities falls upon paraprofessionals who generally have not received sufficient formal training in utilizing appropriate mental health techniques in interpersonal relationships with residents of those facilities. It is suggested that a model of continuing education for such personnel should include formal in-service training programs, with released time from work, in an academic setting likely to provide a stimulating learning experience. Such an academic setting should be located in a metropolitan area, such as Washington, D.C., Atlanta, Georgia, Nashville, Tennessee, or in a smaller area, such as Tuskegee Institute, Alabama, where institutions of higher education already well-skilled in providing training programs for black females are established and where most—if not all—of needed personnel could be readily obtained. I would suggest specifically that such institutions as Howard University, Tuskegee Institute, and Fisk University-Meharry Medical College be considered as possible training sites. These institutions have had long experience in training, partially or fully, health professionals and paraprofessionals and each of the geographical regions in which they are located contains several long-term care facilities.

I would also suggest that personnel from these various institutions be notified about the possibilites of applying for grants to implement such training programs and that every effort be made to assist them in obtaining needed and sufficient funding.

However, before any serious thought can be given to developing one or more viable models for training black female paraprofessionals in long-term care facilities, it is necessary to identify clearly the expected and actual roles of such personnel as they may relate to mental health. These role expectations and perceptions of actual roles performed (and evaluation of performance) should be obtained from a good cross-section of the paraprofessionals themselves, as well as from relevant long-term care health and administrative professionals, patients, and significant family members or guardians of the patients. Once gaps between expectations and actual practices are determined and consensus of major goals is obtained, then specific and realistic, written job descriptions should be developed for the various types of long-term care facilities involved, and a continuing

educational model(s) could be developed, tested, and, where necessary, modified.

It may even be more crucial to examine carefully the nature of existing training programs designed to prepare paraprofessionals for long-term care facilities, with particular emphasis upon determining the substantive content devoted to mental health in the curriculum. Clearly a number of technical institutes, junior college programs, and even, on occasion, high school programs currently involved in training such paraprofessionals could benefit by including needed content in their ongoing curricula.

I feel strongly that is is very important to initiate or upgrade training in mental health in these various curricula within high schools, vocational schools, or other technical training programs so that students would be certified to work in the field following the completion of the course or courses. Some attention should be given to developing internship programs in conjunction with the formal training on the high school level, underwritten by such funds as those available from the Neighborhood Youth Corps (NYC). Appropriate rewards—including pay for internship in nursing homes under supervision—should be included. Beyond that, there must be significant upgrading in wages and fringe benefits and fewer dead-ending jobs for such workers if there is to be a real attempt to reduce heavy personnel turnover. There may well be a need to consolidate smaller nursing homes, even if it means transferring residents or potential residents to a larger complex since any home under 200 or so beds would be extremely unlikely to provide an atmosphere especially conducive to training and effective utilization of training as well as opportunity for upgrading personnel.

Above all, attention must be given to defining precisely who is to be trained by whom, for what, and when, where, and how. Currently, I believe that any training program designed for black female paraprofessionals should include training personnel who are themselves black.

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Educational Program In Mental Health Care For Personnel In Long-Term Care Facilities

By Borys Kobrynski, M.D., and Philip Wexler, Ed.D.

MENTAL health needs constitute a significant part of the overall health needs of the elderly and failure to meet these needs effectively is a major cause of dependency in old age. Studies have demonstrated that the majority of residents of nursing homes and homes for the aged have seriously impaired mental functioning. Moreover, surveys have also shown that among the elderly living in their own homes, about 15 percent have mental impairments often as severe as those encountered in elderly patients admitted to mental hospitals.

Many misconceptions concerning normal aging and mental dysfunction in old age still persist among health professionals and the general public. For example, custodial care too often is considered to be the only way to deal with the mental aberrations of the elderly. While many nursing homes have established elaborate rehabilitation programs for physical disabilities using modern physical medicine modalities, very little has been done to improve or preserve the mental functioning of the elderly.

Traditional academic education and inservice training in nursing homes and similar facilities so far have offered very little practical instruction in the care of elderly people with age-related mental disabilities. There is an urgent need to establish a program of continuing education which would assure that the fruits of experience and new knowledge in mental health care of the elderly are available to all persons caring for the elderly in any setting: nursing home intermediate care facility, home for the aged, private home, or mental institution.

The goal of the suggested program is assurance of good care for the mentally infirm among the elderly as a direct consequence of services provided by well-trained caretakers. Good care is usually predicated on careful preparation of multidisciplinary personnel for the difficult task of caring for elderly people afflicted with multiple disabilities. To achieve this goal, preparation of trainers in mental health care of the aging is required. The training program should be built around the team concept and involve multiple disciplines. Priority for enrollment should be given to persons engaged in or assigned to inservice training of staffs in long-term institutions. The educational program should be open also to properly selected community people not associated with long-term facilities who would form a cadre of instructors available for on-the-job training of staffs of small facilities who otherwise would be unable to organize an inservice program for their personnel.

MODEL OF AN EDUCATIONAL PROGRAM FOR INSTRUCTORS IN MENTAL HEALTH CARE FOR THE AGED

Ten days of basic education will be spread over a two-month period. Subsequently, for four months the trainees will attend each month a one-day follow-up institute. Various types of educational methods will be used: lectures, workshops, demonstrations in selected nursing homes and mental hospitals and field experience. Following the completion of the basic course by trainees, clinical demonstrators will visit the institutions participating in the program to observe the trainees in the performance of their duties and to discuss difficult

problems with them. Total duration of one course would be six months.

The program of instruction will cover the following subject areas:

A. The aging processes: biological, psychological and social;
B. Mental and intellectual function in old age;
C. Age-related mental disabilities;
D. Methods and approaches designed to preserve mental health in old age;
E. Therapeutic modalities for improving the functional level of the mentally impaired elderly;
F. Instructional methodology and techniques, curriculum planning and development.

It is highly desirable to have an evaluation process built in the model. The evaluation process should include but not be limited to:

A. Teaching Methods and Techniques
   Various teaching approaches and materials and an ongoing evaluation of the effectiveness of a particular technique or method.
B. The following characteristics will be assessed after the completion of the course:
   (1) Knowledge, attitudes and instructional skills of trainees;
   (2) Effectiveness of the trainee in the institution before and after completion of course;
   (3) Relationship between effectiveness of the trainee in the institution and occupation or profession of the trainee;
   (4) Influence of the trainee on the staff of the institution by discipline;
   (5) Influence of the trainee on the physical environment of the institution.
C. The Patients
   Assessment of the effect on patient care, namely changes in the type of care with particular emphasis on benefits derived by patients.
D. Evaluation Methodology
   The following methods will be used:
   (1) Tests
   (2) Questionnaires
   (3) Observations of clinical demonstrators during field experience
   (4) Rating on the job after completion of the course by clinical demonstrators and institutional supervisors
   (5) Assessment of patients by a questionnaire tested and found useful in an experimental survey of patients.

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Inclusion Of Mental Health Concepts In A Continuing Education Model

By Jeannette R. Kramer

NO therapeutic community can accomplish its aims without a teaching program for all staff members which is given first priority. On the other hand, a teaching plan alone is not sufficient to establish a therapeutic atmosphere. Most of the published studies of rehabilitation experiments in geriatric institutions have assumed—incorrectly—that teaching techniques to staff is all that is required. What is overlooked, with the result that often little is accomplished, is that it is impossible to rehabilitate patients in a custodial institution without rehabilitation of the entire institution itself.

Two interlocking/relationship systems are being dealt with here— 1) the professionals and their assistants working primarily within the institution as an organized team and 2) the patient and his emotionally significant family members who have requested service from the institutional system. "System" is being used here as social scientists use it who have in recent years applied general system theory to human interaction. Like all systems, the long-term care system and patient-family system function according to basic principles. Any happening which affects one part of the system affects the rest of that system and, in turn, the other system, thus setting up circular feedback patterns.

The concept of systems has important application to institutions which are trying to change. In the first place, in order to start using new concepts, it is necessary to start at the top and change the entire institution.

In the second place, a system maintains a balance. As soon as a change is initiated, resistance is encountered, forcing one back to his original position. Long-term care patients are very difficult to change. First, staff attitudes and methods of communication must be changed. Staff members must use all their combined powers to get chronically disabled patients to work with them.

To change staff attitudes, one must first know what they are. Communication has to be opened up so that every patient and every staff member can be heard, and hidden conflicts and hidden agendas can be brought out into the open to be dealt with.

To achieve this, nursing homes need mental health consultants with group process experience who can help set up a therapeutic milieu such as progressive psychiatric institutions have developed since the fifties. This person is a catalyst to the system—stimulating it slowly but surely in the direction of change for growth. Even one day a week is enough to keep it moving. He will teach staff members to deal with relationship and group living problems and with depressed, regressed and confused patients and their families.

The mental health consultant works with all personnel from the very top down, helping to develop a team with communication between departments, shifts, and levels of function. When an institution has this type of openness, then mental health concepts can be taught and used.

A comprehensive training program is needed including general staff meetings, supervisory meetings, floor meetings, community meetings, and participation in rounds. Quite useful in understanding pathological behavior is the theoretical framework provided by a psychodynamic approach to people and their interrelationships, especially when new contributions from the fields of child development, small group dynamics, family processes, communication theory, and videotape with instant replay are brought in.

It is becoming more and more evident that the era of the non-professional is here. It is possible to teach psychodynamic principles in an intellectually honest form to any staff members, regardless of educational

background. In an open system, with training, supervision and feedback, the aide can carry a lot of responsibility in the slow-moving, chronic care facility. His role might include active participation in community meetings with patients, leading reality re-orientation groups, co-interviewing as a member of a team with patients and their families, leading group exercises and functioning as a rehabilitation and activity aide, participating in staff meetings by sitting on panels, and taking part in role playing, shift meetings and feedback sessions.

Skills that allow the aide to perform these functions can be taught in staff training sessions. Aides need to learn not only to make a bed, give a bath, and feed a patient, but also to motivate him and to listen to him without taking sides. Staff can be taught communication skills, including methods of conflict resolution—whether among patients, among staff members, between patients and staff, or in areas involving the patient with his family or with members of the outside community.

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New Directions In Training For Continuing Education In Mental Health

By M. Powell Lawton, Ph.D.

THE multi-service center has the capacity to provide total multi-disciplinary exposure in a training situation. The strict definition of treatment roles along the traditional mental health disciplinary lines has been recognized as a liability for some time. This recognition has generally not been translated into effective action in the usual university-based program. Physicians serve clerkships and residencies; social workers have their field placements, and psychologists have their supervised practica. These procedures make it easy to socialize new recruits into their prospective professional roles, but they actively block the development of the whole-person perspective so necessary in effective treatment of the elderly. Mental health is the province of the aide, the community worker, and the housekeeper, every bit as much as the nurse, the occupational therapist, or the psychiatrist. Direct exposure of each to the perspectives of the others during training is necessary to the achievement of what Arthur Waldman has aptly called the mental health of the treatment setting.

In very concrete terms, this means that curricula must be planned by an interdisciplinary team that is able to think in an essentially *non*-disciplinary way, that practicum training is handled by the assignment of students from these many disciplines to a single treatment milieu, and that ample opportunities are provided for exchange of ideas among disciplines via seminars attended by all universities; and technical training programs have unfortunately made this kind of interchange difficult. The multi-service center is fortunate in having facilities where this professional ecumenism flows naturally from the treatment needs of real human beings.

Fragmentation among important segments of the total treatment system can be bridged by the multi-service center. Currently, there is an unfortunate lack of coordination between the training efforts of many of the important establishments in the tinkering trades. I suggest that the multi-service center has a naturally-occurring position with regard to this network of interested parties that gives it a special capability to bring them together in a special effort. Treatment personnel have individual links to professional organizations, whether national, regional, or local. Many such organizations flounder, recognizing their responsibilities for continuing education, but lacking direct patient-contact facilities for training. The multicare center is able to offer its innovative staff who are active members of the professional organizations and its treatment situation as learning facilities for members of professional organizations who seek expertise to carry back to their service organizations. It seems that our major organizations—The American Association of Homes for the Aging, The National Association of Housing and Redevelopment Officials, The American Nursing Home Association (the single discipline organizations) and even the Gerontological Society—have neglected the resources of the leading centers of practice, while centers like ours have not organized our resources in such a way as to be able to offer them most efficiently to the groups searching for training opportunities.

The community outside the service organization is a resource that has been insufficiently developed. Ladies' auxiliaries and boards of directors represent existing links to the community that require greater attention in a broadband training effort. Totally neglected thus far, as both trainees and trainers, are families of elderly patients, and residents of the community in which the facility is located.

The squandering of resources is a sore point. Both Arthur Waldman and Elaine Brody have alluded to the types of training opportunities the Philadelphia Geriatric Center provides. It would be more than embarrassing to count up the expenditures in manpower that it has cost the PGC to respond to the disparate and uncontrolled inflow of requests for training opportunities. We have responded by establishing the position of director of education, but have a long way to go to arrive at a point where our maximum efficient contribution can be made. I suggest that this point would be most approachable through the establishment of a combination of practicum and interdisciplinary instruction.

We suggest a later conference for the concerned personnel of multicare facilities to map out ways in which facility-based training can be designed. These newly-trained instructors can then become experts in their own facilities and the nucleus for the spread of this continuing process of education.

We suggest the preparation of a series of packages, repeating training programs that can be put on either at the centers or on the sites of interested consumers in other areas of the region, such as Community Mental Health Centers, state hospitals, and nursing homes. An essential element of the package should be the snowballing of the training roles beyond the individuals who begin the process of training. In other words, the trainees should be trained so as to facilitate their becoming trainers, regardless of whether they are direct-care personnel or top-level administrators.

Robert C. Linstrom is the Executive Director of the Seven County Health Planning Council in Wooster, Ohio.

The Comprehensive Health Planning Agency And Nursing Home Trainer

By Robert C. Linstrom

THE concern of a professional planner charged with the responsibility for an areawide comprehensive health agency is the development of an appropriate range of facilities and services for the elderly in the area. The area of activity of the Seven County Health Planning Council of Wooster, Ohio, encompasses a wide variety of institutions—from those that offer high-quality long-term care to the converted residence type. Its mental health facilities have a diversity of professional, semi-professional, and paraprofessional personnel.

Planning for an adequate offering of services and facilities necessitates consideration of the quality of care provided by these programs. Many of the personnel employed in the institutional and non-institutional agencies in the Wooster area have only minimal exposure to mental health concepts and to basic emotional needs of older people.

Thus, it is imperative that areawide health planning agencies bring together resources from within an area, as well as from state and federal operations, to help develop continuing education programs for such personnel. These should be geared toward enhancing the understanding of the needs of the patients and hence the quality of care. The planning agencies should recognize this dimension as being as significant as the adequacy of the physical structure, the financing structure, etc.

All areas have some resources available to assist in providing continuing education programs. However, guidelines for the content of such programs are needed and areawide health planning agencies should have a role in helping develop them.

Edward J. Lorenze is the Director of the Burke Rehabilitation Center, White Plains, New York.

Education In Rehabilitation For Allied Health Personnel

By Edward J. Lorenze, M.D.

THE Burke Rehabilitation Center, an affiliate of Cornell Medical Center-New York Hospital, developed a three-year, regional demonstration program in Continuing Education for Allied Health Personnel under the sponsorship of the New York Metropolitan Regional Medical Program beginning in February, 1970. Since that time, more than 3500 personnel from institutions in a four-county region have participated in training programs. These educational offerings were held at 38 different locations in the region and varied from one-day institutes to two-week skills training courses, totaling 28,265 manpower training hours.

The major goal was to *increase the knowledge and improve the skills of personnel engaged in giving patient care*. The majority of the 3500 participants were employed either in long-term care facilities or within the chronic care division of an acute general hospital. The specific goals of the project—which we feel should be included in any regional continuing education project—were as follows:

1. *Design course content to meet regional needs;*
2. *Make education and training geographically accessible to personnel;*
3. *Plan time convenient to personnel;*
4. *Enlist the cooperation of health care facilities and educational institutions;*
5. *Relate education and training to the job for all levels of personnel;*
6. *Involve institutional personnel in the teaching as well as in the planning of courses;*
7. *Integrate program with existing regional education and training activities.*

There are continuing requests within this project for courses with mental health content, e.g., psychological aspects of supervision, motivation of patients, reality orientation, etc. Our experience over the past two years supports the conviction that there is a substantial number of allied health personnel who want to improve their skills and increase their knowledge. They will do so if the education and training offered are closely related to their job, convenient in time and location, and do not pose a financial strain.

We believe that an important source of mental health manpower in institutions is the people already employed. One of our major unmet needs is a work-study system which permits employees to earn while they learn. A centralized training program shared by several hospitals is a partial solution to the problem of small hospitals in orienting and training newly-hired workers who may only number one or two persons at any one time.

The mental health content appropriate for inclusion would depend upon the functions of the personnel participating and their proposed use of the content. Based on our experience, this might include:

Knowledge of personality theory and function
Knowledge of abnormal psychology
Knowledge of methods of intervention with individuals
Knowledge of the uses, effects and abuses of chemotherapeutic agents
Knowledge of other cultures and value systems
Knowledge of self

Skills training might include interviewing, observing and recording, group skills, instructional skills, consultation, community process, problem-solving, data gathering, reporting, activities leadership, and communications.

It would be ideal if evaluation methods, tools and monies were adequate for determining the impact of

continuing education upon the quality of patient care. However, to be more realistic and practical in evaluating efforts expended on the project, since funds for this purpose were limited, we focused on determining if the objectives and content of individual courses were appropriate for the audience, if the participants felt that it was relevant to their jobs, their level of satisfaction with the program, and their suggestions for improving future presentations of the subject matter. Instruments such as questionnaires, checklists, open-ended questions, opinion questions using Likert-type scales and the Kropp-Verner scale (an attitude scale for evaluating short-term educational experiences), were used profitably to this end.

Dulcy B. Miller is the Administrative Director of the Nursing Home and Extended Care Facility of White Plains, Inc., White Plains, New York.

A Continuing Education Program Designed To Encourage Continuity Of Care And Coordination Of Services To The Ill Aged Individual

By Dulcy B. Miller

IMPLICIT in the development of continuing education programs in mental health for personnel concerned with the long-term care of the elderly is a recognition that the program be centered about the aged person in whatever setting he may be. The physical, social, and emotional health of the aged are not constant. As their health status changes, older persons may move from home to hospital to home with the help of home health services. Or the aged may be admitted to an extended care facility or a nursing home directly from their own homes or after hospitalization. It is essential that staff in all the agencies serving the aged have an understanding of the psychosocial needs of their clients.

Educational programs may be developed in two patterns—within a single discipline and in a multidisciplinary framework. For example, staff of the general hospital are loath to work with the brain-damaged patient whose senile behavior may, in fact, have been exacerbated by hospitalization. Hospital nurses in particular have difficulty in the management of the intellectually-impaired patient. It is suggested that all nurses in a given community, in the general hospital, nursing home or home health agency be invited to learn together about the mental health needs of older persons. Joint instructional plans would help to elevate the quality of nursing care for psychiatrically ill older people in all locations.

It is useful to have professionals, including physicians, psychologists, social workers, and physical therapists, study and discuss common problems in order to develop the team approach needed in the therapeutic program for the aged who are psychiatrically ill.

With these introductory remarks it is proposed that a continuing education model for personnel in long-term care of the elderly be structured around an academic and clinical setting in urban, suburban and rural environments. Specifically, the suggestion is that in the New York area the Program of Continuing Education at the School of Public Health at Columbia University organize a series of courses to be offered in New York City, in White Plains, and in Hunterdon County, New Jersey. Available resources such as the New York School of Psychiatry, The Psychiatric Institute, Columbia University's Department of Community Psychiatry, local Mental Health Clinics and the State Department of Mental Hygiene will cooperate with Continuing Education to develop the program. All aspects of the course, curriculum development, teaching, program design, and evaluation will be done in conjunction with cooperating mental health agencies and institutions. Courses will be based on both the disciplinary and multidisciplinary approach described above. During each course there will be ample opportunity for participants to meet both in workshops comprised of members of their own discipline and in multidisciplinary groups representing the health team. This model provides for the development of these two important aspects of the professional role.

In addition, each class day will comprise both didactic and case presentations. After lecture and discussion sessions in which new information is presented, participants will work in small groups with teams of experienced health professionals. These workshops will be held in institutional settings and will be based on demonstrations and case presentations of patients and

their families. Depending on the nature of the content material, workshops will be disciplinary or multidisciplinary. Expert teams will include health professionals including the physician, social worker, psychologist, clergyman, nurse, recreation worker, speech, physical, and occupational therapists. Ample opportunity will be provided for questions, group interaction and problem solving.

The substantive content of the model course should include the following:

1. The meaning of mental health problems of the aged resulting from:
   a. *changes in life situations such as retirement, loss of a spouse, etc;*
   b. *organic brain disease;*
   c. *functional disturbances of behavior pre-existing the aging process, often superimposed on senility.*
2. Manifestations of mental health problems in the aged;
3. Distinguishing features of organic brain syndrome and other psychiatric disorders found in the aged person;
4. Modalities of treatment available for managing the aged patient with psychiatric problems:
   a. *supportive psychotherapy*
   b. *individual and group therapy*
   c. *milieu therapy*
   d. *recreational therapy*
   e. *drugs*
   f. *restraints*
5. Some common physical disorders found concomitantly in the brain-damaged aged and their influence on patient management;
6. The role and problems faced by professionals in the treatment of the aged patient with psychiatric disabilities;
7. The role of the family in the treatment program of the psychiatric problems of their elderly relatives;
8. The interrelationships of professional groups in the treatment program of the mental health problems of the aged including:
   a. *nursing*
   b. *social work*
   c. *physical therapy*
   d. *occupational therapy*
   e. *recreational therapy*
   f. *volunteer services*
   g. *pastoral services*
9. A discussion and demonstration of specific management techniques, taking the view of each discipline, e.g., nursing:
   a. *counselling with patient*
   b. *counselling with family*
   c. *dealing with death and the dying patient, his family, other patients, staff*
   d. *prevention and treatment of fecal impactions*
   e. *prevention and treatment of decubitus ulcers*
   f. *adverse drug reactions*

When the problem indicates a health team approach the discussion will be from a multi-disciplinary point of view.

The basic or overview course will touch on each of the topics described above. A most important part of the model is provision of advanced courses which will deal in depth with the individual topics of the preliminary course. An attitudinal study should be completed at the onset of the course and repeated at a future date to evaluate the effectiveness of the educational model specified.

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A Pattern For Continuing Education For Mental Health In Long-Term Care Of The Elderly

By Eric Pfeiffer, M.D.

TRAINING for mental health work with elderly patients must be approached systematically.

Mental health services must form an integral part of the entire system of care for the elderly patient.

By the same token, mental health training must interdigitate closely with other forms of training for health and social services for aging patients.

It may be useful to list the generic services which may be needed or consumed by elderly persons requiring long-term care; this list includes but is not all-inclusive:

1. Multi-dimensional quantitative evaluation of functional level in the areas of
   a. physical health
   b. mental health
   c. social resources
   d. economic resources
   e. capacities for the activities of daily living (ADL)
2. Medical treatment
3. Nursing services
4. Counselling and/or psychotherapy
5. Counselling of family members
6. Psychotropic drugs
7. Social interaction
8. Physical therapy services
9. Recreational services
10. Personal care services
11. Food services
12. Hotel services
13. Legal consultation
14. Legal surrogate services
15. Financial assistance
16. Transportation
17. Vocational rehabilitation
18. Assistance in finding employment
19. Relocation in the community
20. Day-care services
21. "Respite" care
22. Coordination of services. (*The latter is the most important of all services and is usually missing from most service packages.*)

It is obvious that certain kinds of services are clearly in the mental health field where others are marginal to it and still others are not particularly related to mental health activities at all. Those services strictly in the mental health field include counselling and/or psychotherapy, counselling of family members, psychotropic drugs, and probably most important of all, coordination of services. Traditionally, social workers have fulfilled this role most admirably. Those in the area related to mental health but not constituting direct mental health services include social interaction services, recreational services, some aspects of personal care services and of vocational rehabilitation, assistance in finding employment and relocation and placement services, as well as certain aspects of day-care services.

The remaining services are primarily performed by other non-mental health experts.

TYPES OF MANPOWER

Mental health manpower in the long-term care field should function at several levels:

1. There should be a focused mental health services component in the long-term care system;
2. There should be a general understanding of mental health needs and mental health services on the part of other professionals and allied health personnel working with the aged.

In other words, certain segments of the manpower system should be given full mental health training as it applies to the aging patient, (social workers, psychiatrists, psychologists, mental health aides) whereas certain other segments of the care system (from administrator to internist to registered nurse, to occupational or recreational therapist, to nursing aide, to dietary and laundry personnel) should be given some training in mental health matters.

CURRICULUM CONTENT

Curriculum content should focus on:

1. *Events and stresses occurring commonly in late life (retirement, death of spouse, loss of income, loneliness, loss of functional roles);*
2. *Knowledge regarding the commonly occurring psychiatric conditions in old age, particularly emphasizing functional psychiatric disorders such as depression, hypochondriasis, transient situational stress reactions; adjustment reaction to old age, paranoid reactions, and sleep disturbances, as well as occasional alcoholism and organic brain syndrome, reversible, and irreversible;*
3. *Treatment approaches to psychiatric problems in late life including psychotherapeutic, psychotropic, and environment-changing approaches;*
4. *Knowledge regarding other aspects of aging, including the aging person's physical health, matters of family constellations, living arrangements and housing, community services for the aging, information regarding Medicare and Medicaid as well as Social Security and other federal and non-federal programs providing financial assistance to the aging, knowledge regarding legal services, and so forth.*

LOCATION OF EDUCATIONAL PROGRAMS

The site of educational programs designed to provide such training for services with the elderly should be those in which similar activities are currently proceeding, that is, in university medical centers, in state mental hospitals, in some nursing homes, and in some community colleges. It is not at all useful to construct entirely new centers for training for these special purposes. Pedagogical and knowledge skills of existing professionals must be utilized and existing administrative structures should be reshaped in order to accommodate the specific purposes rather than to create brand new administrative structures; also, additional educational and programmatic materials need to be generated in order to accomplish the several levels of training in this field.

EVALUATION OF TRAINING PROGRAMS

It is well known how difficult it is to evaluate training programs, whether they be in medical schools, nursing schools, in schools of social work, or in other educational programs such as in Ph.D. programs in graduate schools. Some suggestions, however, should be made. Focus on the persons being trained is paramount among priorities. As a minimum, inventories at the beginning and the end of the program should measure growth in knowledge of the service personnel, their attitudes toward the aging, and their morale.

Second, some "patient satisfaction" measures should also be utilized. These would include attention to the patient's evaluation of (a) professional competence; (b) cost-convenience assessment; and (c) personal satisfaction derived from participation in the program.

Manuel Rodstein and Mitchell M. Waife are Chief of Medical Services and Executive Director, respectively, of the Jewish Home and Hospital for Aged, New York, N.Y.

Models For Continuing Education In Mental Health For Personnel In Long-Term Skilled Care Of The Elderly

By Manuel Rodstein, M.D. and Mitchell Waife

THE Frederic D. Zeman Center for Instruction in Care of the Aged was initiated in 1963 for the purpose of giving instruction to all types of persons caring for the aged, particularly in long-term care institutions.

The courses have been based on both practical and theoretical considerations in an institution with a program of comprehensive treatment for all ranges of functional capacity for over 1,300 aged individuals including a Home Care program, Health Related facilities, Nursing and Hospital areas and an apartment residence.

The teaching staff is composed of medical and other professional staff of the sponsor augmented by guest lecturers from a wide variety of disciplines.

The curriculum has included subjects such as psychiatric problems, architectural planning, behavioral sciences, leisure time activity, medicine, nursing, nutrition, occupational therapy, pharmacy, physical rehabilitation, social work and courses accredited for the training of administrators of nursing homes required for licensure examination and continuing education.

Lecture and demonstration courses on a one or more a week basis, and one to three day institutes devoted to particular subjects have been given both at the Jewish Home and Hospital for Aged and at outside centers given on the job site during or after work hours.

More than 5,000 students have participated in these courses and institutes in the last nine years, 1,396 in the last two years, 393 of whom were being trained for the nursing home administrator's license.

Since the inception of the program the mental health of the residents has been considered in every aspect of the curriculum using the entire Jewish Home and Hospital for Aged as a teaching facility.

In addition to the institutes and courses which have included sessions or have been devoted entirely to mental health, emphasis has been given to the mental health aspects of a wide diversity of courses devoted to other subjects.

Institutes devoted entirely to this subject have included "The Team Approach to Medical and Psychiatric Problems of the Aged," with over 100 participants and this year one on "Modern Concepts in Geriatric Neuropsychiatry" which was attended by over 200 social workers, administrators, physicians, nurses, graduate students, etc., including sessions on recent advances, the practical management of the aged in the community and institution, protective services, activity programs and nursing services.

A recent two and one half day session for physicians included one half day devoted to "The Interaction of Physical and Emotional Factors in the Aged."

Specific lecture courses in the curriculum devoted to mental health have been given under the titles of "Geriatric Neuropsychiatry"; "Psychiatric Aspects of Aging"; "Psychological Aspects of Institutional Life"; "Reality Orientation", among others.

The students, representing a wide range of disciplines, have included social workers, administrators, recreation workers, occupational therapists and assistants, registered nurses, licensed practical nurses, nurses aides, activity leaders, physicians, volunteers and aspirants for such positions as well as those beginning or changing careers.

Selected physicians from Israel, Venezuela, Australia, Argentina and Great Britain have been trainees for three month periods in the various activities of the center. A joint program is currently being planned with Teachers College of Columbia University for clinical training of candidates for master's and doctor of philosophy degrees in fields related to gerontology.

Mr. Gene Schorzmann is the Supervisor of Community Services at Iowa Lakes Community College, Estherville, Iowa.

Tentative Model For A Continuing Education Program

By Gene Schorzmann

THE goals set for the tentative model for a continuing education program for Merged Area III, covering five Iowa counties, are (1) to build a favorable attitude toward retirement living by providing worthwhile pre-retirement information and courses to all citizens, especially those between fifty to seventy years of age; (2) to create an understanding of the mental and physical aspects of the aging process through in-service education for all levels of long-term care facility personnel; and (3) to utilize activity programs to promote among the long-term care facility residents positive attitudes regarding the aging process as well as involvement in the community.

To achieve the first of these goals, the Adult and Continuing Education Department of Iowa Lakes Community College has, for the past three years, offered the following pre-retirement courses as a community service: Need for Pre-Retirement Planning; Changing Roles: From Work to Leisure; Legal and Financial Planning; Employment after Retirement; Health and Welfare, and Continuing Education and Leisure Time Activities.

The model proposes to expand this service by offering pre-retirement courses monthly in each town with more than a 1,000 population, the age range of participants being approximately fifty to seventy. Sessions will run three hours.

Also projected is an extension of in-service training programs for the personnel of long-term care facilities. These have been placed into 13 identified levels including those who work directly with the residents: administrators, stewards and matrons, registered nurses, licensed practical nurses, nurses' aides, activity directors and social workers; the maintenance staff covering housekeepers, dieticians, and launderers; bookkeepers and secretaries.

In-service program topics previously presented in Area III Nursing Homes cover a wide area: those relating to the purely physical as sanitation, oxygen and suction therapy, definition and observation of vital signs and diet as well as the psychological-sociological as nurse-family, nurse-patient relationships, dehumanization versus dignity, and the philosophy of geriatrics.

The model aims to strengthen and implement these course offerings.

Other points currently agreed upon in connection with the proposed model are (1) that the places where these courses are to be offered will be determined by the number of participants from a given level residing in a given area; (2) that the cost of instructional personnel will vary greatly; (3) that the program will have a full-time coordinator: and (4) finally and most importantly, it will be Phase I of a broad community-wide program for the aged.

The Iowa Lakes Community College program, unique in that it links the community with the long-term care facility, has been organized by Mrs. Aileen Schacherer, Continuing Education Coordinator.

Frances G. Scott is the Director of the Oregon Center for Gerontology at the University of Oregon, Eugene, Oregon.

Robert E. Taubman is an Associate Professor with the Department of Psychiatry and the Division of Family Practice at the University of Oregon Medical School, Portland, Oregon.

A Regional Training Model In Mental Health Aspects Of Long-Term Care

By Frances G. Scott, Ph.D. and Robert E. Taubman, M.D., Ph.D.

THIS statement outlines a proposed educational model for the continuing education of personnel of long-term care facilities in mental health concepts and the special mental health aspects of aging and long-term illness.

The model has the following objectives:

1. *To establish for Health, Education and Welfare Region X (the states of Alaska, Washington, Oregon, and Idaho) an integrated on-going program which will disseminate information about the mental health aspects of aging and long-term illness, including new research findings, new and successful nursing and/or administrative practices which contribute to the good mental health of patients, and new or improved skills and techniques in working with the mental health needs of patients;*
2. *To develop a Planning and Advisory Board on Continuing Education and Mental Health Aspects of Long-term Care for Region X to assist the administrator(s) of the regional model program in assessing the need for various specialized curriculum content, evaluating the impact of the educational program, and planning new program components;*
3. *To develop—and to encourage and promote the development by others—of new educational materials relevant to mental health education, including films, videotapes, audio tapes and cassettes, slide/sound presentations, film strips, books, monographs, pamphlets, syllabi, bibliographies, and other written materials;*
4. *To insure the continuity of the educational program thus established.*

This model education program will be conducted conjointly by the Oregon Center for Gerontology, a four-campus consortium engaged in multidisciplinary education in gerontology, and the Department of Psychiatry and the Division of Family Practice, University of Oregon Medical School. Administration will be handled by the University of Oregon, the campus handling the funds of the Oregon Center for Gerontology.

These two components of the Oregon State System of Higher Education are particularly equipped to focus on the phenomena of death, dying, bereavement and mourning as aspects of mental health problems of aging and long-term illness. The University of Oregon has for four years offered a seminar, "Confrontations of Death", which has achieved national recognition. The University of Oregon Medical School has sponsored continuing education for physicians in the phenomena of death and dying, and Dr. Taubman has recently begun video-taping interviews with dying patients and their

families. Educational materials produced thus far include these videotapes, as well as a book of readings and a documentary 16 mm film used with the "Confrontations of Death" seminar at the University of Oregon.

The model program will have as its two principal design components: 1) the development of a three to six month internship for nursing home administrators in the mental health aspects of long-term illness; and 2) the development of a systematic, continuous series of short-term workshops on selected topics of mental healtn problems of long-term care, selection and stabilization of a qualified staff to conduct them, and the delivery of these workshops to various locations in the four states that comprise Region X.

The internship program as well as the workshops will deal with various aspects of mental health involved in death, dying, bereavement, and mourning; the emotional components of serious illness and chronic disease; the psychology of aging, both normal and pathological; the sociology of aging; and policies and practices to enhance the emotional good health of patients in extended care facilities.

The model program should be evaluated in at least two ways: 1) assessment of attitude/opinion changes on the part of a long-term care staff completing an educational component or unit (this may be one workshop, a series of workshops, or the internship program); and 2) assessment of change in patient care philosophy and practices in long-term care facilities with varying degrees of involvement in the educational program.

An Evaluation Team will be established, with members from appropriate departments of the University of Oregon and the University of Oregon Medical School to develop an evaluation design and the necessary instruments.

In the field of gerontology, the Oregon Center for Gerontology involves a large number of basic science disciplines and professional fields in its university-based curriculum on four Oregon campuses; in addition, there is a Certificate Program in Applied Gerontology available through the Oregon Division of Continuing Education. The Medical School also has a strong continuing education program for physicians and other health personnel, providing a recognized source for mental health education.

While there was no time to call together a representative group of specialists in mental health and gerontology before the preparation of this statement, the following persons from Health, Education and Welfare Region X were contacted and contributed to the development of this statement: Margaret M. Danner, Chairman, Board of Examiners of Nursing Home Administrators and Administrator West Hills Nursing Home (Oregon); Marvin M. Janzen, Coordinator, Alaska Regional Medical Program; Carolyn Jeffers, Education Director, Washington State Health Facilities Association; Lucile Russell, Coordinator, Lane County Mental Health Center (Oregon); Martha J. Scharpf, Education Chairman, Board of Examiners of Nursing Home Administrators (Oregon); and J. H. Treleaven, M.D., Clinical Director, Oregon State Hospital.

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A Three-Step Plan To Upgrade Long-Term Institutional Care For The Aging

By Mary E. Shaughnessy, M.S., R.N.

CONTINUING education in long-term care for the elderly should assist all levels and types of personnel involved in the care of patients in understanding the principles of mental health and its implications in practice; aid administrators (and administrative staff) to understand and consider the mental health needs of personnel in relation to assignments, work loads, benefits and need for recognition; educate all levels of personnel to understand mental health problems common to the aged, long-term patient; and introduce staff to the resources available from the community which may be utilized to meet the mental health needs of aging patients.

It must be assumed that the majority of personnel currently employed in long-term care institutions have little knowledge or understanding of mental health concepts; that personnel have minimal insight into common mental health problems such as confusion, depression and anxiety in the aging; that in current practice little consideration is given either to the mental health needs of staff or to patients; and that most long-term care institutions neither know about nor utilize available community resources to improve patient services or to upgrade the competency of the staff.

A three-step plan is proposed to upgrade long-term institutional care for the elderly. *Step One* aims to

Plan and implement programs for administrators and directors of nursing (and other health professionals to be included i.e., occupational and physical therapists) to provide them with basic knowledge as indicated in objectives;

Provide equal emphasis on content as it relates to patient and staff;

Offer programs on a regional basis, content to be presented over a six week period, so that participants could apply learning to practice between sessions;

Utilize regional resource people for instruction so that participants become acquainted with them and can call on them on a continuing basis after the course has ended;

Suggest that a case study approach with carefully developed "homework assignments" would be most useful;

Encourage institutions to send administrator and director of nursing together to the course for maximum benefit, the course to be offered on a university or college campus in the particular region.

The objective of *Step Two* is to

Plan and implement a series of training programs to be offered within long-term care institutional settings (for personnel of one or more nursing homes) to help staff to understand their own mental health needs and to learn about the mental health needs and problems of the patients under their care;

Include RN's, LPN's, aides, orderlies, dietary and housekeeping personnel and any others in direct contact with patients and their families;

Provide opportunities for personnel to identify problems and to test out solutions;

Use actual case material within institutions;

Teach in so far as possible at the "bedside";

Provide the opportunity for all personnel in all hours of duty to be involved in the program;

Plan program over a period of time to allow participants to apply learning, making provision for necessary guidance and supervision;

Utilize in so far as possible resource people who

can continue to provide consultation on a continuing basis;

Provide for evaluation.

Finally, *Step Three* will

Develop demonstration projects within facilities to provide help to other groups;

Establish conferences for family and relatives aimed at helping them to understand patient needs and problems so that they can assist in meeting goals for patient care;

Develop patient/resident groups to help them understand their own needs and to assist them in adjusting to congregate living;

Provide training programs for volunteers involved in giving services to the institution.

Sylvia Sherwood is the Director of Social Gerontological Research at the Hebrew Rehabilitation Center for Aged, Roslindale, Massachusetts.

Recommendations For Upgrading Environment In Institutions For The Aging

By Sylvia Sherwood, Ph.D.

BEFORE proceeding to a discussion of the environment of long-term care facilities for the aging, it is necessary to make some basic assumptions about such institutions.

It is clear that training and educational programs should be interdisciplinary in nature and that research and training go hand in hand. To ensure a solid knowledge base, to produce continually better "products and services", and to provide "quality control", it is important to stress the necessity for systematic collection of relevant data and continued research in connection with program efforts along with some basic training in understanding research methods and interpreting research results.

Emphasis should be placed on *QUALITY* of care, but it is important that there be a shift in the definition of quality of care from emphasis on formal qualifications of personnel or resources to emphasis on the "impact" of the personnel, services and general institutional environment on the mental status, psychological functioning, and life satisfaction of the patient. As pointed out by Anderson and Stone in discussing the quality of nursing home care, "In an examination of standards—that is, assumptions about what quality is—it becomes apparent that attention has focused mainly on . . . how that care affects . . . conditions . . . Evaluating the quality of . . . care . . . (is) a task of relating the care actually given an individual to some statement . . . of . . . goal achievement potential. Then quality could be measured, not in terms of *input* (facilities, staff, and other resources) or in terms of *output* (what programs and activities are undertaken or participated in), but in terms of *outcome*: is the patient restored to and maintained at the best level of functioning possible."

It should be emphasized that it is not enough to trace changes in the resident over a period of time. Controlled comparisons are necessary. In order to draw conclusions about impact there must first be a basis to conclude that observed changes *would not have taken place anyway* with the particular intervention. Very often the best that can be expected is a slow-down in degenerative processes. If only the "before and after" conditions of such persons are observed, a downward pattern may be seen and failure incorrectly assumed.

To some extent this criticism may apply to many investigations in which conclusions are drawn concerning the negative effects of institutionalization. While depression, apathy, loss of function, negative self-image and high morbidity and mortality rates have been rather consistently demonstrated, rarely have these studies been conducted with an adequately controlled research design. Lieberman, Anderson and others have pointed out that possibly these negative characteristics are attributable to selection factors rather than to the institutional environment itself. It may be that maladjustment, physical and mental deterioration may be precipitating factors to institutionalization rather than emerging from it.

Mechanisms need to be developed and implemented to feed back relevant findings from research to administrators, clinicians and other personnel (as well as the patient and his family) directly involved in the long-term care process.

Education and training should extend to all levels—from administrators, physicians, social workers, nurses and other professional personnel to the non-professional workers such as maintenance personnel, waitresses, cleaning persons, etc. The problem of maintaining a full

complement of non-professional personnel is paramount in many urban institutions. Lack of prestige for such personnel may be a significant factor in job turnover. Although the specific skills required are less important than the personal qualities, these persons do in fact play a significant role in the daily lives of the residents of such institutions. Efforts should be made to raise the self-picture of these personnel and treat them as part of the clinical team caring for the aged.

The foregoing assumptions having been discussed, the institutional environment may now be considered.

One area of investigation that it is believed should be given increased emphasis in educational and training programs involves the analysis of factors in the operation of an institution that can have important effects on the mental and emotional state of the residents. While requiring a great deal of further study, research in this area already offers important clues that should be included in the content of such educational programs. For example, every institution has a "site", an architectural design, a staff and a set of operating procedures for providing requisites to survival, including shelter and space for activities of daily living, food and drink, clothing, at least a minimum of health care, and finally protection from such environmental hazards as fire, unsanitary conditions, theft, abuse, etc. There is increasing evidence that such factors undoubtedly do and can be used to affect the mental and psychological functioning as well as life satisfaction of the residents.

The potential significance of the everyday nutritional function of an institution offers an excellent illustration of ways in which such a function can be used to advantage: Kastenbaum has pointed to the use of food and drink as sources of mutual gratification and feelings of personal identity (such as was the case in the beer and wine experiments conducted at Cushing Hospital in Framingham, Mass.)

A pilot study of behavior in the dining hall at the Hebrew Rehabilitation Center for Aged in Boston has indicated significant relationships between a number of social and psychological factors and disruptive behavior in the dining hall. As a matter of fact, this study has had a number of relevant byproducts. During the course of the research an improvement in dining room behavior was observed in those sections where a Research Assistant acted as a participant observer and helped serve the meal. It was believed that this was a result of the added attention to the elderly persons in question. These findings prompted the head of the dietary department, Mr. Edgar Krasa, to consider ways of increasing individualized attention to residents in the dining hall. Rather than remaining in the kitchen to expedite the food serving process, supervisory staff in the dietary department now "float" in the dining hall during meal-time, conversing with the residents. Even more imaginatively, Mr. Krasa decided to give the residents additional personalized attention by changing the style of serving. Rather than serving prepared plates of food from the kitchen, the waitresses bring bulk food to each section on especially designed food carts. The residents are now permitted individually to choose their portions. This innovation has been met with enthusiasm by the residents and it appears that pleasanter meal-time situations will continue in the Hebrew Rehabilitation Center.

It is interesting to note that the decision was made to try this new method even though it was anticipated that it would be more costly. Contrary to expectations, however, it has been found that this new system is both more efficient and less costly. Indeed, there is considerably less wastage in food. The advisability of instituting these practices elsewhere should certainly be considered.

Although apparently rarely used in this capacity, the meal-time can also represent for the institution a particularly important setting in which to initiate or implement innovative therapeutic programs. Similar to the way that the "meal-time" operates (albeit unconsciously) in the socialization process in the home setting, the "meal-time" in the institution can be used to advantage as a medium of social interaction through which knowledge, attitudes and values are communicated and inculcated and desired changes thus more successfully realized.

These are but a few of the many possibilities for exploiting the social functions of nutrition as "handles" for improving the mental and social status of the elderly. The following are examples of the ways in which other aspects of institutional life can affect the resident in long-term care facilities.

Proppe concludes that current data point to possibilities of using the "architectural experience" to advantage in limiting feelings of isolation and dreariness in institutions for the older adult. He also suggests that bright and intense colors can serve orientation and identification purposes—such as using doors of different colors with matching bedspreads and wallpaper as an aid to personal identification with the room as well as using specialized colors for different segments of the facility as an aid in identifying location and the various "common" rooms that serve different functions.

Studies by Ittelson have pointed to relationships between attitudes and perceptions and the use of space and objects. Sommer has studied ways in which space and objects are manipulated by different persons in different situations and relationships between behavior and physical setting. Separate studies by Friedman in a home for the aged and by Lawton and Simon in a

number of institutional settings have indicated the importance of spatial proximity to the development and persistence of social relationships for institutionalized populations.

Weinstock and Bennett found that long-term care patients exhibited strain and reluctance to communicate various problems to nurses of different racial backgrounds. This held true for the majority of patients for problems concerning clothing, leaving the building, and money. This did not appear to be the case for problems concerning doctor's appointments, sickness and roommates. Both for purposes of rehabilitation and efficient administration, such findings suggest the importance of seeking ways to increase mutual understanding and decreasing attitudes of "social distance".

It should also be recognized that differing functions of the various types of personnel in the long-term care institution—administrators, physicians, nurses, social workers and other professionals as well as dietary personnel, cleaning personnel, etc.—are likely to lead to different perspectives which affect the ways in which such persons observe and interpret the behavior of the residents. To increase understanding and promote a consistent approach to the patient it is important to stress the need for devising and implementing methods for cross-communication—at least on some primary level—among *all* the personnel directly involved in the caretaking process or who have frequent contact with the patient.

Stanley H. Smith is the Dean of Fisk University, Nashville, Tennessee.

A Theoretical Or Conceptual Model For Continuing Education For Personnel Concerned With Mental Disorders Among The Aged

By Stanley H. Smith, Ph.D.

THERE are no viable programs in Nashville and the State of Tennessee which really come to grips with the need for continuing education for personnel concerned with mental disorders among the aged. This is, therefore, a theoretical or conceptual model with implications for future programming.

The approach to continuing education in dealing with mental disorders of the aged is realistic. The underlying assumption is that aging is a process and, therefore, the mental status of the aged person is a direct resultant of the totality of the experiences which this person has had in the process of becoming aged. Assessments could then be meaningfully made in terms of those cultural and psycho-social experiences which have not been conducive to the development of a "mentally healthy, mature" person.

Within this framework, the approach must incorporate a developmental and sequential thrust. This philosophy must be carefully spelled out as programmatic guides to the operation of the curriculum of continuing education. By definition also, the approach has to be interdisciplinary with the assumption that one is dealing with the "whole" person. A model for every continuing education approach must be carefully and rigorously spelled out with precise delineation of goals and objectives and built-in evaluative criteria to assess their attainment.

There are additional characteristics which conceivably must be built into this model. A mechanism must be set up for establishing continuing relationships between the agency or institution responsible for the continuing education, the agencies serving the population at risk and the community from which the population comes. This would dictate the importance of really obtaining base line data from the community of the population at risk. This will entail the gathering of demographic data including the variables of race, ethnicity, sex and socio-economic status, data on family life styles and child-rearing practices and information on the basic values of the ecological area, etc.

The basic thrust seemingly must be to develop social indicators which will throw light on the quality of life existing in that locality. The continuing education approach must, therefore, involve the interrelated and appropriate social institutions and social agencies in that relatively homogeneous ecological area. Continuing education must address itself, not only to treatment, but also to prevention and to the reduction of the rate of recidivism to a minimal level.

It is felt that the thrust must be within the framework of community organization and development. The nursing home might, therefore, be divested of its traditional identity and become more of a comprehensive care center occupying an integral position in the community and serving roles and functions generally agreed upon by the members of that community. This center could very well deal not only with the care of the elderly, but also with the care of children. This will be a constant reminder to the staff that the concern must be to the developmental aspects and not to the static dimensions of aging. The services which are performed for and with these children would be relevant and

meaningful to an understanding of the aging process and the aged. Efforts must be made, therefore, to set up community centers and to insure that the continuing education approach be community education and not confined to the staff.

The educational institutions for higher education in that community must accept the primary responsibility for this kind of continuing education. These educational institutions will be in the position to understand and deal with the unique configurational problems of the community brought about by the dominance of a racial group and/or of a particular socio-economic status. This will call for special definitions of mental disorders leading to a particular epidemiology and different treatment programs and methodologies. This will highlight concern for and awareness of the kind of quality of life in that community conducive to a "wholesome" and "meaningful" community life. This will be of therapeutic value and will have some relevance to increasing the efficiency of treatment.

The following suggestions might be relevant to Nashville, to the State of Tennessee and possibly to the states of the Deep South:

> *There is an overriding need to develop some sensitivity to the special needs and problems of the aged of the different racial and ethnic groups. This is basic in the United States and it is directly related to many other problems including mental disorders. Other concerns which relate to the above and which compound the problem are the variables of sex and socio-economic status.*

Fisk University is located in the center of the North Nashville area. This is an ecological area inhabited primarily by Blacks. Fisk University has a long-term involvement in the Black community and has a graduate training program in Social Gerontology. This University can, therefore, accept primary responsibility for the continuing education approach. It is able to do the following:

1. *Lead the way in demographic studies;*
2. *Become more concerned with community organization and development and the role and function of the aged and the evaluation of the quality of life conducive to a minimal frequency of mental disorders among the aged.*

The above could be additionally accomplished by Fisk University accepting responsibility in collaboration with Meharry Medical College for:

1. *Short-term workshops for administrators of nursing homes in Alabama, Tennessee, Mississippi and Kentucky;*
2. *Short courses in methodologies of research and evaluation with some emphasis on resocialization and remotivation. This training will encompass an evaluation of the operations of nursing homes in terms of indices of effectiveness.*

This holistic approach seemingly will be continuing, will involve the community, will be functional, and at the same time preventive.

Prescott W. Thompson is Associate Clinical Professor of Psychiatry and Ambulatory and Community Medicine at the University of California at San Francisco.

Content For Mental Health Training

By Prescott W. Thompson, M.D.

THIS statement addresses itself solely to the "mental health content" of an orientation or continuing course for those who work—or will work—with the aged. It limits itself to brief comments about principles or emphases considered to be important to personnel at all levels within congregate living facilities.

These personnel should be aware of the following:

- . . .*the principle of mastery—the importance to older persons (most of whom have lost much) to do what they are able to do, to experience being on top of things in as many areas as possible, to remain at the helm of their own destinies as long as possible;*
- . . .*the importance of the "lifeline"; i.e. that the older person selects someone (a member of the family, chaplain, physician or staff person) to be symbolically the one who can be depended upon to be there when danger threatens;*
- . . .*the importance of continuing contact (to the fullest possible extent) with the world beyond the walls of the institution (via TV, newspapers, radio, walks, rides, concerts, sports events, etc.);*
- . . .*the importance of providing for broad, flexible programs based upon individual differences, i.e. programs which are broad enough to respond to many individual tastes, interests, wishes, skills and limitations;*
- . . .*the importance of staff at all levels listening for direct or indirect expressions of what is important to the individual and reporting such to the nurses, occupational therapist, social worker, physician, administrator or other appropriate person;*
- . . .*the importance of an atmosphere in which aggressive impulses may be expressed freely and without censure (within reasonable limits); as a matter of fact, where criticism or other expression of verbal aggression is encouraged;*
- . . .*the importance of taking away nothing from the older person which does not have to be taken away—including privacy, the choice of his companions, money, liquor, tobacco, sex, or the freedom to choose what he wishes to do or not do;*
- . . .*the importance of being free to express the wish to die (or the feeling that there is little left to live for) and the importance of staff conveying what is heard to other appropriate staff. In any event, expressions of the wish to die should be accepted as an effort to communicate something—a latent communication which deserves response to whatever it is (a bid for attention, a suicidal wish, a genuine wish to die for the right reasons, a need to talk with an appropriate person about feelings, an expression of boredom or a commentary on an oppressive atmosphere or inadequate program, etc.)*
- . . .*possible emotional, behavioral, or mental effects resulting from physical illness or disequilibrium such as nutritional deficiency, anemia, insulin reaction, heart failure, recent stroke, drug toxicity, etc.*

Above all, staff should recognize the importance of trying to know and to understand the older person as a person (vs. the stereotype of "old man", "crock", etc.)—i.e. who he is now, where he has been, what he has done or has seen during his life, what has interested him, what he likes and does not like, what he takes pride in, what he would like to do or looks forward to, etc.

Wilda H. Ziga is a Consultant in Gerontology in Clearwater, Florida.

Expansion Of Existing Educational Systems In A Florida Retirement Community To Include Mental Health Components

By Wilda H. Ziga, R.N., M.A.

THE sunny climate along Florida's Gulfcoast attracts numerous retirees, winter visitors, and tourists. Although Pinellas County offers these elderly residents a variety of living arrangements and a high concentration of long-term care facilities, mental health care for the aging is practically non-existent. The present educational systems in this retirement community could be expanded to include mental health components.

Many care-givers involved in the delivery of services to the aged population are recruited "with no experience or training necessary". Pay is low and the turnover is high. A registered nurse at one of the better nursing homes, who reported a take-home pay of $2.50 an hour, said that her aides could make more bagging groceries. "We wouldn't dare train our aides—they would quit and go to a hospital where the pay is higher," said another.

The morale of patients is lowered by the constant change in workers as well as by the fact that new workers often bring their own negative feelings about growing old and approaching the terminal phase of life. They may be dissatisfied with their own lives, have little in the way of job choice, and view their work as temporary as they drift from place to place.

Because of these problems, the focus on mental health should aim at both the care-givers and the care-recipients. Improved working conditions and an increase in the level of job satisfaction would result in more stable workers. Positive attitudes would hopefully lead to humanizing the care of the patients as well as contribute to the mental well-being of visiting family and friends.

To accomplish favorable behavioral changes, an on-going in-service educational program developed for all levels of personnel involved in long-term care of the elderly is necessary. Mental health components interwoven into a concept of total care would combine preventive, rehabilitative, and supportive measures and thus improve the overall quality of service. Emphasis on a multi-disciplinary approach to the education of the staff is essential. The "healing team" should include physical therapists, occupational therapists, speech pathologists, gerontologists, social workers, clergymen, volunteers, and other human service technicians, in addition to physicians, psychologists, nurses and ancillary workers. Each person on the team needs to feel a part of the "common goal"—important to the overall success of the program.

With scarcity of staff and resources, it is necessary to direct efforts toward expansion of existing educational systems to include mental health components. Teaching costs can be kept lower when duplication of faculty, professional personnel, facilities, and agency support is avoided. If the model is fed into the system of education rather than set up as an autonomous entity, the program can continue to meet the needs of the community after the grant funding is no longer available.

St. Petersburg Junior College, with three campuses throughout the county, has recently developed some unique health-related programs using an extended campus concept. Courses were designed around a "Core of Knowledge" for Nursing Home Administrators to prepare them for licensure in the state of Florida. Course content included some components of mental health such as the psychology of patient care, personal and

social care, and services in long-term care. A series of workshops on "The Biological, Social, and Psychological Aspects of Aging" were presented in collaboration with the Florida Nursing Home Association, and a symposium on "Man's Right to Die" was sponsored jointly with District Nurses Association.

The Florida Regional Medical Program has put seed money into a three-year model system for continuing education for health professionals (multi-disciplinary in approach) through cooperative arrangements between local health care institutions and the community college. Phase II of the project—"The In-Service Program for Nursing Homes"—is presently being developed.

Although the community college has taken an active part in continuing education, their model lacks mental health components and funds are needed for expansion, more faculty, and greater depth of services. Suggestions for innovative procedures and approaches include (a) a van to carry equipment and audio-visual aids (such as cartoon type films to add humor to aspects of mental health teaching) to individual nursing homes; (b) outreach programs to aged people living in hotels and adult communities; (c) educational health services (including mental health) to the aged using adult education facilities; (d) half-way houses for the elderly who could be graduated from nursing home care; (e) a more home-like atmosphere in nursing homes; and (f) in-service training for personnel in long-term care facilities.

An effective model could enhance the quality of life for the elderly by such measures as arranging transportation for visitors to a state mental hospital; encouraging young people to volunteer their time and attention to lonely older persons; separating pathologically disturbed patients from those who are still alert; grouping nursing homes together for combined in-service programs; sending faculty and gerontologists to visit the elderly as the visiting preacher used to make his rounds; and establishing bereavement clinics for families who have lost a loved one.

Out of the educational model it is hoped that, eventually, different operational models will be developed. One might build on the concept of the Oriental philosophy that there are two kinds of orphans—both the young who have no family, and the old who have outlived their relatives. These two kinds of orphans could live together in a housing complex, eating, working, and playing together. Testing could be done by the college, special people trained as Human Resources Technicians (graduates of a two-year program) could work with the group, and it would serve as an ideal laboratory for students in related courses. The old people could help teach the young ones their skills, and the young members could help the old by writing letters, doing errands, etc. A mutually beneficial experience for both the young and the old would be the goal of this kind of demonstration.

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CONFERENCE FORMAT

SUNDAY, MAY 14

4:00 - 7:30	Registration	Lower Level Lobby
7:30 - 9:30	*Opening Session*	Francis Scott Key Room
	Greetings and Introductions	Dr. Jerome Kaplan Executive Director Mansfield Memorial Homes, Inc. Mansfield, Ohio, and Immediate Past President of the Gerontological Society
		Dean Walter M. Beattie, Jr. Dean, School of Social Work Syracuse University Syracuse, New York
		Hobart C. Jackson Administrator Stephen Smith Home for the Aged Philadelphia, Pennsylvania, and Session Chairman
	Opening Remarks	Ruth Knee Special Assistant to the Deputy Administrator for Health Services, HSMHA
		Dr. George Maddox Chairman, Education Committee, Gerontological Society; Professor of Sociology and Program Coordinator, Duke University Center for the Study of Aging and Human Development

MONDAY, MAY 15

Breakfast is served in the Fairfield or Stirrup Restaurants, Lobby Level

Session Chairman: Walter M. Beattie, Jr. — Georgetown Salons

9:00 - 10:30 Presentation of Two Models of Continuing Education Programs

A Regional Approach: Texas
Dr. Hiram Friedsam
Dr. Robert H. Dovenmuehle
Joyce Hoover
Edward Gibbs
Dr. Herbert H. Shore

A Therapeutic Community Approach: Philadelphia Geriatric Center
Elaine Brody
Dr. Leonard Gottesman
Dr. M. Powell Lawton

10:30 - 10:45 Coffee and Rolls

MONDAY, MAY 15 – (Cont'd)

10:45 - 12:00	Presentation of Models by Communities and Regions Comments and Discussion	
12:00	Buffet Luncheon	Windjammer Room, Top Floor
1:15 - 3:00	Continuation of Presentations and Discussion of Models	
3:00 - 3:10	Coffee	
3:10 - 5:00	Continuation of Presentations and Discussion of Models	
5:00 - 6:00	Reception	Gerontological Society Suite Room 425
8:00 - 10:00	To be determined	

TUESDAY, MAY 16

Session Chairman: Dr. Jerome Kaplan — Georgetown Salons

9:00 - 10:30	Discussion of Elements of Model Continuing Education Programs: – Priorities for Populations to be Trained Discussion led by Dorothy Moses – Content Appropriate for Inclusion in Training Programs Discussion led by Dr. Rodney Coe
10:30 - 10:40	Coffee and Rolls
10:40 - 12:15	– Training Techniques Discussion led by Dr. Herbert Shore
12:30 - 1:30	Luncheon
	An NIMH Response: Nathan Sloate Special Assistant to the Director, NIMH
1:45 - 3:30	Concluding Session

Response to Conference and Ideas for Follow-Up
Discussion by Representatives of NIMH
Thomas G. Webster, M.D., Chairman

Discussion

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